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ORIGINAL LECTURES.

DIGITAL EXPLORATION OF LUMBAR ABSCESSES.

A Clinical Lecture delivered in the Mercy Hospital, Chicago (Service of Edmund Andrews, M.D., and E. Wyllys Andrews, M.D.),

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Were it possible to lay open a lumbar abscess throughout its whole extent, and treat it thoroughly in every part as an open sore, we would eliminate nearly all its dangers, except in tuberculous cases. Now, by thorough digital examination of their interiors, followed by resolute incisions and tubing, we approximate to this condition of safety. Let us see what may be done for the patient before us on this principle.

He is not aware of the real nature of his disease, but supposes he has a hip disease. There is a large fluctuating tumor on the outer side of the left thigh, below the trochanter, but pressure, rotation and friction of the joint surfaces upon each other elicit no pain. There is no hip disease. I now make a free incision into the abscess and evacuate almost a quart of pus. Introducing my finger and long probes I trace the cavity, not to the hip joint, but upwards and backwards into the sciatic notch, where it enters the pelvis. We will insert a large drainage-tube and explore at a higher point. Just over the posterior part of the crest of the ilium there is an old fistulous orifice, too small and contracted to allow a free discharge of pus. This, I suppose, opens into the same inner passage which goes downwards through the pelvis, out of the sciatic notch and into the great abscess of the thigh. We will open it widely and cut off the supply of pus to the cavities below.

Introducing my finger. I find the usual expansion of the sac under the skin, with a narrow inner orifice leading to the interior of the body. I enlarge this inner passage with the bistoury, and now can insert my finger into the cavity of the trunk behind the thickened peritoneum. At this point I find a channel extending down towards the sciatic notch, and also a pouch-like passage running forwards along the internal iliac fossa and expanding into a sac behind the region of the anterior superior spinous process and the outer third of Poupart's ligament. Here the thickening of parts and pressure of the abscess have pushed away the peritoneum, making plenty of room for another incision. Passing a bent metallic staff into this pouch I feel the pressure of its extremity, and cut down upon it from without, with a free incision. I can now introduce a finger into the anterior orifice, and another into the posterior one, and bring them together in the cavity. We will next pass a large drainage-tube through, leaving an end out at each orifice.

Returning to the posterior incision, I insert the finger again, and trace another channel upwards behind the bistoury and within the lower ribs. I now cut down upon my finger just below the twelfth rib, alongside the common mass of the spinal muscles, and carry another long and large tube down from this orifice, bringing its lower end out through the orifice below, alongside the posterior end of the iliac tube. We can trace with the probe a canal running still upwards to the ninth dorsal vertebra, where we find externally the usual projecting knob characterizing Pott's disease. Here is the fountain-head of the pus which has burrowed through all the long and complicated passages below, exhausting the patient, not by drainage, as the old surgeons said, but by the want of drainage, or more accurately, by the absorption of putrid pus from all these vast interior surfaces, which will now collapse down upon the tubes and become healed.

There still remains the short passage from the upper orifice to the carious bone. We might excise a portion of the ninth rib behind, and endeavor to scrape away all carious bone from the vertebra, but in doing so we should have to deal with the ninth intercostal artery, which winds across the body of the affected vertebra in a situation which renders it pretty difficult of management. Our incisions and tubing below, followed up with antiseptic injections, will relieve the patient of most of the causes of his debility. The upper short segment of the channel between the upper incision and the affected bone is too small in extent to cause great debility, and we will inject it daily with antiseptics, under which treatment not a few cases will heal, the carious spicules of bone being partly washed away and partly absorbed. If this result be not accomplished, we will resort to a plan by which I have often removed dead bone from different parts of the body inaccessible to instruments. I refer to the solvent use of diluted hydrochloric acid, a resource which is strangely neglected by most surgeons. To carry out this plan it will be necessary to open the intercostal space op-

posite the affected vertebra, widening this space, if necessary, by cutting a broad notch in the rib below.

Now, passing up from the incision below a sound or catheter, and identifying its location by touch or by the use of needles, we cut into the abscess cavity at its very fountain-head. If the dead bone be found loose, we can then pick it out; if not, a tube is inserted well against the bone, and being attached to a fountain syringe full of diluted hydrochloric acid, it transmits a quart of the solvent slowly against and across the carious spot. This is repeated daily, and if the bone is fairly reached by the tube every dead particle is effectually dissolved out. The incision is kept well open by a good drainage-tube until the cavity within is healed.

When the lumbar vertebræ are affected they are much more accessible. The finger can come directly upon them, and there being no intercostal arteries there, they can be scooped and scraped, if one simply avoids the aorta and the vena cava. A few days ago I explored such a case. Opening into the abscess alongside the erector spinal muscle, I found a pus cavity about five inches long extending up and down, and perhaps two and a half inches wide. In it lay two very small pieces of dead bone, which I removed. The third lumbar vertebra had been affected with caries, causing the usual external deformity. Exploration by the finger within showed a considerable concavity in the side of the body of the vertebra, but it was fully healed, being firm and well covered with granulations. The size of the cavity showed that much more bone had been lost than was accounted for by the pieces found. The remainder must have been either absorbed or washed away.

A careful examination by the finger and the probe showed that the caries was completely healed, and that under simple tubing and antiseptic injections the abscess will be permanently cured.

ORIGINAL ARTICLES.

THE VALUE OF BINIODIDE OF MERCURY AS AN ANTISPETIC IN OBSTETRICS.[1]

BY EUGENE P. BERNARDY, M.D.

At a meeting held June 4, 1885, I had the pleasure of reading before this Society a paper on the "Value of Biniodide of Mercury as an Antiseptic in Obstetrics." It was with hesitancy that I brought forward the claims of a new agent whose properties were at that time comparatively unknown. My only knowledge of its effects was that which I had derived from reading the experiments of Dr. Miquel, of France, and from my experience in three cases. To-night I again bring it to your notice, not as an unknown and untried antiseptic, but as one which has proved itself far superior to any of this class of preparation which I have thus far used in obstetric practice. Since writing my last paper I have learned that the biniodide of mercury has been used for the past year in preference to all other antiseptics at the Lariboisière Maternité, of Paris, and the reports of the results obtained have likewise been highly favorable.

In a letter written by Dr. Thos. Linn from Paris, France, to the *Philadelphia Medical Times* (March 6, 1886), referring to the subject of antisepsis, the following passage occurs:

"Professor Panas has again something to say about antisepsis in eye-surgery, principally in the treatment of cataract. The principles that guide him are, first, to make use of an antiseptic that is *sure* and *not irritating* in its action. . . . . Of all the antiseptics which he has used during the last two years, Dr. Panas has now definitely adopted a solution of the biniodide of mercury in 20 to 1000 ($\frac{1}{20}$ to 100?).[1] Even in 40 to 1000 ($\frac{1}{40}$ to 1000?), this salt possesses a very strong anti-fermentative power, so that at double the strength nothing should resist it. . . . . As to the other antiseptics used, boric acid is not irritating, but its antiseptic power is doubtful; the bichloride of mercury is more irritating than the biniodide, and its antiseptic power is not half so great."

These remarks fully substantiate the opinion expressed in my former paper, that "I considered the biniodide of mercury far superior to the bichloride of mercury as an antiseptic." Of course, the cases of Dr. Panas belong to eye-surgery; but still the experiments made in both classes of cases led to the same conclusions.

I have here the history of eight other cases in which I found it necessary to use the biniodide. I have perhaps given a fuller detail of circumstances than may appear necessary. If I so erred, I have done it for the purpose of fully and clearly showing under what conditions the antiseptic was used.

It will be observed how readily offensive odors disappeared after only a few injections of the biniodide. In some of the cases the odor around the patient was perfectly horrible.

Case 1.—On September 9, 1885, I was requested to attend Mrs. F., residing at Fifty-fifth and Vine Streets, in her fifth confinement. Her previous labors had taken place in Belgium, and had always been terminated by the forceps; only two children being born alive. The first and third lyings-in were complicated by attacks of puerperal fever.

I arrived about 2 P.M. Found the patient had been in labor since the previous evening (8 P.M.) On examination, found the os completely dilated, head presenting, while to the left I felt what seemed to be a prolapsed cord. The head seemed jammed between the promontory of the sacrum and the pubes. I ruptured the bag of waters so I could make a more decisive examination. Down came a loop of non-pulsating cord, which proved to be irreducible on account of the position of the head. The presentation was now made out to be a partial brow; an antero-posterior contraction existed; the promontory of the sacrum caught the side of the head and pinned it in position. I attempted to push the head up, but

[1] Read before the Obstetrical Society of Philadelphia, April 1, 1886.

[1] Evidently an error in proportion, as in the formula given it is 1-20 gramme to the litre, or 1 to 20,000.

soon found it could not be done. I then attempted to produce flexion, and failed. Wallace's forceps met with similar results; on account of the unnatural position of the head, the forceps constantly slipped. By this time I was completely exhausted. I gave one-half grain of morphiæ sulph., which would insure the patient needed rest, as her pains had all along been active.

On my return at 5 P.M., found the condition of things the same. Dr. A. E. Roussel, who came with me, etherized the patient. I again attempted to change the position of the head, but failed. Pagot's long forceps were applied, but on the slightest traction they would slip. Tarnier's forceps seemed to grasp the head in a firmer manner, but they finally gave way. I had now worked continuously for two hours. Seeing there was no other resource, I perforated the head, and within twenty minutes the child was extracted, which weighed, without the brains, fifteen and one-half pounds.

The patient was living on the second floor, in a room partitioned off the main room of a factory. The room was well located and freely supplied with fresh air; her husband was the nurse. The next day found the pulse 100, temperature 101°; extreme tenderness over the abdomen, especially over the region of the uterus. I washed out the uterus with the $\frac{1}{15000}$ solution of the biniodide of mercury, and left orders to have it done four times a day. The second visit found the patient free from pain; pulse 80, temperature 98⅛. Convalescence went straight on as in a normal labor. On the fourth day there was considerable pain over the uterus. Towards evening, while washing out the vagina, a clot of blood about the size of a pigeon's egg was expelled, perfectly free from odor. The patient was up on the eight day.

Case 2.—Was called (October 5, 1885) to attend Mrs. Mc., age 30, third confinement. After an easy labor she was delivered of twins. The placenta came away naturally, and everything went well up to the evening of the sixth day, when she became feverish and thirsty. The vaginal discharges became highly offensive, so much that the windows had to be constantly kept open. I immediately ordered injections (hot) of the $\frac{1}{4000}$ solution of the biniodide of mercury, asking the patient to note particularly when the odor disappeared. The first injection was followed by no effect; but on the second injection being made, the odor disappeared and remained so during convalescence. Discharged on the tenth day, well.

Case 3.—On the morning of October 7, 1885, I was called to attend Mrs. B., age 28, sixth confinement. About a month previous she had called at my office, and I had given my opinion that the child she was carrying was undoubtedly dead, and that she was likely to fall in labor at any time. On my arrival at the house, found, after examination, the os perfectly dilated and the bag of waters protruding between the vulvæ. Ruptured the bag of waters, and of all stenches I never smelled the like. The windows had to be thrown open. On pushing my examination, found a small hydrocephalic child descending. Labor was lingering, but finally the child (in a putrid condition) was expelled naturally. The placenta came away without any trouble.

I ordered the patient to be washed out with $\frac{1}{4000}$ solution of the biniodide of mercury four times a day. The first injection I administered myself. The second and third injections were followed by a slight stinging sensation, which I believe came from using water which was too hot; but, to make certain, I reduced the biniodide to the $\frac{1}{8000}$. Within two days the discharges became perfectly odorless. Each injection was followed by a feeling of ease and comfort. Discharged well on the ninth day.

Case 4.—On October 23, 1885, I was requested to attend Mrs. R., in her fourth confinement. Her third lying-in had been followed by a severe attack of puerperal fever. Upon examination, found the os rigid, dilated about an inch; waters ruptured; vertex-presentation, right occipito-posterior position. Labor was lingering, os remaining somewhat rigid. About 9 P.M., finding that no headway had been made, and the patient by this time showing symptoms of exhaustion, she was then fully etherized. I then applied Wallace's forceps and delivered her of a living child; no laceration. The next day she complained of pain over the region of the uterus. Ordered one-eighth grain morphiæ sulph. in tablespoonful of camphor-water every two hours. On my next visit found the tenderness had increased and the discharges from the vagina were becoming offensive. Ordered hot injections of the $\frac{1}{4000}$ solution biniodide of mercury. The following day the discharges were free from odor, the tenderness of the uterus abated. Discharged well on the fourteenth day.

Case V.—On the morning of November 3, 1885, I was asked to see Mrs. C.; first confinement. In this patient a year previously I had dilated a constricted os. Pregnancy was ushered in with marked kidney trouble; the urine yielded over thirty per cent. of albumen. The patient was enormously swollen from dropsical effusion. The case from the start was not a promising one. On arriving at the house, found the patient very nervous; on examination, found the os slightly rigid, but dilating, the waters ruptured; labor dragged on slowly all day, with very little advance. Towards 12, midnight, she suddenly went into a spasm. I immediately etherized her. By the time she was completely etherized Dr. Curtin, whom I had sent for, arrived. On examination the os was found dilated, slightly rigid; the ether was pushed, with the effect of softening the os. I then applied Simpson's forceps, but they would not hold; Wallace's long forceps were applied, and in a short time the patient was delivered of a fine bouncing boy; no laceration.

The next visit found the patient doing well; pulse about 80, temperature normal. On my second visit the temperature was 120°, pulse 120–130, great fever, excessive tenderness of the uterus, the discharges very offensive. This sudden change was caused by the stupidity and incompetency of the nurse. The nurse being discharged, the mother of the patient undertook to nurse her. I immediately ordered hot injections of $\frac{1}{4000}$ solution of biniodide of mercury.

The second injection the odor disappeared, but in this case did not remain away; I believe it was on account of not having a competent person to use the injections. Even as imperfectly as my orders were carried out, the biniodide held the odor under control, as the discharges were never as offensive as before its use. The patient was discharged well on the fifteenth day.

Case 6.—On November 11, 1885, I attended Mrs. L. in her fifth confinement; her last two confinements had been followed by puerperal fever. She had been delivered by an excellent and careful obstetrician. She dreaded the present confinement. On arrival found the child was born; in a short time the placenta came away. The next visit found the patient doing well, with the exception of some tenderness over the uterus. Being compelled to leave the city, I handed the case over to Dr. A. E. Roussel. On his first visit the patient was feverish, pulse 100, temperature 101°, discharges extremely offensive, excessive tenderness over the uterus. Internally, 2 grains of quinine and ⅛ grain morph. sulph. were ordered every three hours, and four times a day hot injections of the $\frac{1}{4000}$ solution of the biniodide of mercury. On his next visit found the patient better and the discharges free from odor. The patient was discharged on the ninth day well, feeling satisfied that the *red pills*, as she called the pellets of the biniodide, had saved her from another attack of puerperal fever.

Case 7.—Mrs. B., on December 28, 1885, miscarried about the fifth month. On my arrival at the bedside, found the fœtus had been expelled early during the day; the hæmorrhage had been excessive; on examination, found shreds of placenta in the vagina, could detect a larger portion in the uterus. The patient declined any interference, stating that it would come away itself. The patient lived in a small, ill-ventilated house, up a court, having for nurses the neighboring women. Gave freely of ergot, but without effect; within twenty-four hours the odor from the vaginal discharges was highly offensive; ordered the $\frac{1}{4000}$ solution of the biniodide of mercury to be thrown up the vagina four times a day; a few injections readily dissipated the odor. On the fifth day the remaining portion of the placenta came away, free from odor. The patient was discharged well on the tenth day.

Case 8.—On March 26, 1886, I was requested to attend Mrs. ——, wife of a physician. On my arrival at the house found that labor pains had set in about 4 A.M. Saturday morning; examination showed the os soft and dilating, waters broken, vertex presentation. Labor continued throughout the day, and terminated naturally at 10:15 P.M.; no rupture of the perineum, but the mucous membrane of the vagina, just behind the posterior fourchette, yielded to the extent of half an inch; there was a tendency to post-partum hæmorrhage, which was readily checked by compression and the administration of ergot. Next day, pulse 92, skin rather hot, natural flow from the vagina. On my next visit, Monday, March 22, pulse 130, temperature 103½°, pain over the left side of the uterus; the uterus appeared flabby, not having well contracted. Same day at 5 o'clock, pulse 130, temperature 104°, discharges from the vagina highly offensive. Ordered the vagina to be washed out with a solution of carbolic acid (twenty per cent.), ten grains sulphate of quinine morning and night, and twenty drops tincture of digitalis every three hours. Midnight, same day, pulse irritable, quick and compressible; pulse 128, temperature 103°, the discharges from the vagina still offensive. Next morning, temperature and pulse the same, no change. Ordered the $\frac{1}{4000}$ solution of the biniodide of mercury to be thrown up the vagina, and if possible into the uterus; the injections were administered by the husband, and were thoroughly applied. On the 24th the condition of the patient seemed improved; temperature 102°, pulse 115–120.

On the next morning the husband called at my house and informed me that his wife was in every way worse; the pulse was so irregular that he could not count it; temperature 104°; patient vomited several times; tendency to diarrhœa. I asked Dr. Goodell to meet me in consultation. On arriving at the bedside of the patient, found her in a remarkably good condition; pulse 100, temperature 102°; examination showed a slight laceration of the mucous membrane in the vagina, uterus was contracted; treatment to be continued, with this addition if the case did not get along well: To use 10-grain vaginal suppositories of iodoform in conjunction with the biniodide injection. These suppositories were not used, as the case from this day did well, with this exception, that on the 27th of March, or the seventh day of confinement, she was allowed to get up and use the night-vase. This was followed by a severe secondary hæmorrhage, which was checked by hot-water injection and ergot. From this time the biniodide was used, the vaginal discharges were free from any offensive odor, and it seemed to have a decided influence on the temperature. The patient is still under treatment.

We have here eight cases added to the three of my first paper, making in all eleven cases. This certainly gives us sufficient data to draw conclusions.

The deductions drawn from my early cases are fully sustained by my subsequent experience, and in my mind fully establish the value of the biniodide of mercury as an antiseptic in obstetric practice.

In my first series of experiments, to make my solution of the biniodide I took 1¾ grains of the salt, placed it in a mortar, and gradually broke up its particles, after which I slowly added one pint of boiling distilled water. This gave me a $\frac{1}{4000}$ solution. This took a long time, and often alchohol had to be added to dissolve the mercury.

Mr. J. F. Hayes, of St. George Pharmacy, conducted a series of experiments for the purpose of placing the biniodide in the hands of the physicians in a convenient and readily soluble form. To obtain this end pellets were made of three different strengths. In making them sufficient iodide of potassium was added for the purpose, though not enough to cause any chemical change with the biniodide. The following is the method pursued in making the pellets: Both salts should be perfectly dry. The potassium iodide is first placed in a mortar which has been

slightly warmed (just enough to take the chill out of it, and thoroughly powdered; the biniodide is then added and well mixed, but not rubbed hard, or the powder will be apt to cake. Care must be taken not to compress the pellets too hard; they keep just as well and are more easily dissolved when they are compressed just hard enough to make a firm pill. The following is the formula for the pellets:

$\frac{1}{4000}$=mercuric iodide $3\frac{21}{25}$ grains, potassium iodide 2 grains. Mix as above, and compress in pellet.

$\frac{1}{8000}$=mercuric iodide $1\frac{23}{25}$ grains, potassium iodide ¾ grain. Mix as above and compress in pellet.

$\frac{1}{15000}$=mercuric iodide $1\frac{6}{2500}$ grains, potassium iodide ½ grain. Mix as above and compress in pellet.

In this form the preparation can easily be carried in the satchel. When required for use one pellet is to be added to a quart of hot water (110°). It dissolves easily, and does not stain the clothing or bedding.

The strength which I generally use is the $\frac{1}{4000}$. Should it appear too strong the pellet can be cut in half or twice as much water used, thus giving a $\frac{1}{8000}$ strength.

221 South Seventeenth Street, Philadelphia.

SAN DIEGO VERSUS THE ORDINARY DISEASES.

BY C. M. FENN, A.M., M.D.,

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Inquiries concerning this climate in its bearing upon disease are so frequently addressed to the writer by members of the profession and laymen, that I venture to furnish a list of questions and responses. For this purpose I avail myself of a series of interrogatories sent to me by some one who is apparently engaged in the collective investigation of diseases. (?) The subject may be of increased interest to some by reason of the multitudes of people that are at present coming to this locality from all directions. Within a twelvemonth thousands have been added to the population and hundreds of thousands to its material wealth. But to the questions.

"To what extent and at what seasons have the following diseases prevailed in your section during the years 1884 and 1885?"

Cholera infantum occurs sporadically, if at all. The temperature is neither sufficiently elevated nor prolonged to produce the typical disease.

Cholera morbus is neither frequent nor influenced by the seasons, owing, doubtless, to the constant presence in market of fresh fruits and vegetables. However, from some unknown cause it was unusually prevalent from August to October, 1885.

Diarrhœa is seldom epidemic. During outbreak of cholera in Spain, however, there was a noticeable increase of cases of diarrhœa in this locality.

Dysentery occurs sporadically only, and without reference to the seasons.

Measles is never extensively epidemic, and not particularly governed by temperature.

Scarlatina. No epidemics of magnitude during the period mentioned. A few cases appeared in the winter of 1884.

Diphtheria and *diphtheritic sore throat* have twice prevailed to a limited extent within the time stated. Death, when it occurs, from laryngeal complications and blood-poisoning.

Croup sometimes prevails during winter months; a predisposition to the disease being an important factor.

Erysipelas. The phlegmonous type rare, and not prone to complicate surgical operations. Erythema, or erythematous erysipelas of more frequent occurrence.

Intermittent fever. I have never seen an endemic, or indiginous, case of chills and fever here.

Remittent fever. A mild type is sometimes met with among children during autumn months.

Typhoid malarial fever is certainly never endemic, and rarely found here.

Typhoid fever is comparatively unknown. We have a California typhoid, without the intestinal lesion, a version of Hamlet, so to speak, with the Prince left out.

Cerebro-spinal fever. Sporadic cases have been reported. Do not think this climate congenial to it.

Phthisis pulmonalis. There are always some cases, but they are generally imported. Native races are not wholly exempt. I have never known a white person to contract it here.

Rheumatism. Sporadic cases of the acute form occur. Chronic rheumatics prefer this to many other coast climates.

Pneumonia is never epidemic. Occasionally met with in wet seasons.

Pleurisy. I do not think it of frequent occurrence. Intercostal and left-side pains are often mistaken therefor.

Bronchitis occurs here chiefly as a sequel, or intercurrent, to other diseases of childhood.

Congestion of the lungs may occur sporadically and after unusual exposure. Consider it a rare malady.

Influenza. An epizootic or influenza (?) has twice been epidemic during the last eight or ten years.

Catarrhal fever. If coryza be implied in the term, we are not wholly exempt during wet seasons. Medical treatment is seldom required.

Enteritis. I have met with two cases during the period named.

Peritonitis, idiopathic, Of rare occurrence here.

Diseases of the liver. Functional disturbances are not uncommon, especially among the unacclimated. Organic lesions, except from intemperance, are rarely found.

Nephritis, acute idiopathic. Not often observed by the physician. A deal of "Safe Cure" is consumed by the laity for flatulence, or tapeworm. (?)

Heart disease. Usually imported. Such cases seek climate as well as others.

Infantile convulsions. Sporadic cases only. This is a terrestrial paradise for babies.

Puerperal fever. I have never had a case in San Diego during a residence of more than twelve years.

Of all the ills, affections of the fauces, such as tonsillitis and follicular inflammations, are most preva-

lent. The former usually ends in resolution, and the latter yields readily to judicious treatment.

Any one desiring further and especially meteorological data is respectfully referred to my contribution to the last census, made at the request of the department.

San Diego, March 10, 1886.

ERYSIPELATOUS ECZEMA.

BY GEO. N. MONETTE, M.D.,
OF NEW ORLEANS, LA.

I have observed, during my past year's experience, a great number of cases of an exanthematous eruption, which, from the prodromal phenomena and the subsequent ultimate pathological phenomena, I am compelled to denominate "erysipelatous eczema." As an initiative, a rigor, with features of a pyretic nature, vertigo slight, a tongue slightly coated, with a metallic taste, some pains, arthritic in locality, urine somewhat highly-colored, pulse somewhat excited and full, consonant with the succeeding turgescence of the cutaneous surface.

The primary features, naturally, so greatly resembling scarlatina, would lead one to diagnosticate a case of the latter named malady, yet upon close observation, it develops into an acute form of dermatitis. There were other features indicating an attack of erysipelas pure, in its primary manifestation, yet there were no bullæ, and no apparent anasarcous condition of the integument, as in erysipelas, but with a vigorously congestive and hypertrophied condition, sometimes corrugated and corded like elephantiasis. Itching was an intolerable accompaniment, yet no wheals were present, as in urticaria, no exudative plastic fluid, as in eczema, and no exfoliation as profuse as in eczema chronicus.

Dermatitis acutus would be a suitable synonym, yet owing to the characteristic features, I think the compound term more expressive. The duration of the malady was from one to three weeks, unlike erysipelas, running its prescribed course within five days, with no unusual developments, as one might apprehend from such an universal congestion, so to speak, of the whole cutaneous surface, with peripheral paresis of neurosal filaments. The last case, as I observed it, presented a pachydermatous condition with rugæ and some exfoliative desquamation, disfiguring the face of the old lady considerably. Her general health was and had always been good, and there were no extraneous concomitants to arouse any suspicion of infection. The features present were identical with those seen previously.

Now as to the causes. I did observe some years since that several cooks whom I had treated developed *bona fide* eczema of the face, neck and forearm. I can recall some of washerwomen who suffered with an eruption on the hands and forearms, yet in these I ascribed the same to the strong chemical and lye soaps used. All were amenable to suitable therapeutics. In the above cases I could detect no cause, other than hæmato-dyscrasia. There were no cases contiguous, no wounds which might have been the media of imbibing or localizing any specific virus.

The therapeutics were such as the cases indicated, principally ferruginous tonics, quinine added, and alkaline ablutions to counteract the intolerable itching or pruritus. Arsenic was combined with the tonics, also ergotin was given to stimulate proper contractility of the cutaneous vessels. One lady, in her incipient development, was annoyed by persistent nausea, which I obviated by a small mercurial with soda. I had had a practicing physician boast to me some months prior, that he had quite a number of cases of erysipelas. If there was any resemblance at all in the cases, I am sure that my cases were not erysipelas. Urticaria has been a frequently recurring ailment in my experience, and has always been susceptible of ready relief. I have not had any so severe as to approximate to the subject of this sketch.

I feel that the symptoms will sustain me in my denomination of the malady, an erysipelatous eczema, the latter characteristic of red eczema.

285 Camp St.

INTUBATION OF THE LARYNX.

BY L. H. DUNNING, M.D.,
OF SOUTH BEND, IND.

O'Dwyer's method of intubing the larynx for the cure of membranous croup being under trial, the following history of an unsuccessful case is written in order to swell the list of recorded cases from which, when large enough, we must draw our conclusions as to the efficacy of the method.

On March 20 I received a note from Dr. J. B. Green asking me to come immediately to Mishawaka to see a patient of his, and to bring my O'Dwyer instruments. On reaching the bedside of the patient I found a child 2½ years old laboring under membranous croup, which had been in progress for eighteen hours. There was marked cyanosis, labored breathing and great prostration. These conditions had been gradually developing for several hours, and had now reached the point of jeopardizing the life of the child. Dr. Green and I agreed that unless instrumental means afforded relief death would be the inevitable result of the attack. Therefore, in what we deemed the discharge of our duty, we proceeded to intube the larynx.

The patient being slightly under size, we selected a tube modeled for a two years' old child. The usual method of introducing the tube was observed, and I found little difficulty in properly placing it in the larynx. The tube afforded marked relief, and when the thread was removed the relief as evidenced by the patient's appearance was striking. She now breathed easily, the cyanosis disappeared, and she passed into a quiet natural sleep. After watching the patient for half an hour, and observing that the tube caused but little local irritation, and that the patient continued to breathe and rest easily, we directed that she should take as nourishment only warm milk, and then left her to the care of efficient nurses.

March 22, 8:30 A.M.—Pulse 120, respiration 22, temperature normal. Patient had rested well during night. Had coughed considerably on taking milk or

water, but was breathing easily. The skin was of normal hue, and the patient was bright and cheerful, being inclined to notice her playthings.

March 22, 12 M.—Dr. Green reported patient as in a favorable condition. No fever; pulse 118 to 124, and respiration 20 per minute.

March 23, 4 P.M.—Saw the patient with Dr. Green. An entire change had taken place in the condition of the child. The tube was yet in position and there was no obstruction to respiration in the larynx, but there were all the physical signs of an intense and widespread broncho-pneumonia. The attendants attributed the unfavorable change to the imprudence of the father of the child in carrying it from a warm room into a cool one, as two or three hours after the change had been made there were evidences of the development of the lung trouble. The child died at 8 P.M. of broncho-pneumonia.

The tube was removed a short time before death and found unobstructed. The relief afforded during the first two days by the presence of the tube was marked, and it is the opinion of the attending physicians that had not the imprudent act been performed the night of the 22d the child would have made a good recovery.

INSTANCES OF TWO OR MORE CASES OF DIABETES MELLITUS IN MEMBERS OF THE SAME FAMILY OR IN NEAR RELATIVES.

BY AUSTIN FLINT, M.D., LL.D.,

PROFESSOR OF PHYSIOLOGY IN THE BELLEVUE HOSPITAL MEDICAL COLLEGE, NEW YORK CITY.

Number of instances in which complete family histories were obtained, 36.

Number of instances in which but one case in a family was noted, 27.

Number of instances of two or more cases, 10.

No. 1. Father–daughter. (Both cases observed and recorded.)

No. 2. Brother–sister. (Case of sister only observed and recorded.)

No. 3. Mother–son. (Both cases observed and recorded.)

No. 4. Paternal uncle–nephew. (Case of nephew only observed and recorded.)

No. 5. Brother–sister. (Both cases observed and recorded.)

No. 6. Two sisters. (One case only observed and recorded.)

No. 7. Two sisters. (One case only observed and recorded.)

No. 8. Two brothers. (One case only observed and recorded.

No. 9. Two brothers. (One case only observed and recorded.)

No. 10. Father, paternal uncle, two sisters, two brothers. (One case only observed and recorded.)

(Note.) Nos. 1, 3, and 5 are reckoned each as one instance in the thirty-six.

14 W. 33d St.

MEDICAL PROGRESS.

RAPID DILATATION OF THE CERVIX UTERI FOR DYSMENORRHŒA AND STERILITY.—DR. A. H. GOELET of New York, in a paper on this subject, says:

The proper time for dilatation, is from one week to ten days after the cessation of the menstrual flow. Much can be accomplished by preparatory treatment, in relieving the rigidity and congestion of the parts, by using every second day for a week previous to the operation, a tampon saturated with either glycerine or boroglyceride. A string being attached, it is removed by the patient in twenty-four hours, and the vagina thoroughly irrigated with hot water.

The instrument preferred is the Palmer dilator, modified in the following way, viz.: The blades are made thicker near the shoulder, and the outer surfaces flatter, to lessen the risk of injuring the cervical mucous membrane, and to prevent too much spring; and the shoulder is made more abrupt. The amount of separation of the blades is one inch, at a point corresponding with the internal os, when the instrument is in position. For greater convenience, the thumb screw attached to the handles has been transferred to the left side.

The operation is thus performed. The patient having been anæsthetized and placed on a table in a good light, with the second assistant, who may be a nurse, standing to the right of the patient (left of the operator), the speculum is introduced and the cervix exposed to view. Ordinarily the position on the back with a bivalve or trivalve speculum will answer every purpose; but for cases where much flexion exists the Sims's position and speculum are required. Unless it has been previously done, the sound is introduced first to ascertain the direction of the canal. Then, fixing the cervix, and drawing it down slightly with a tenaculum in the left hand, the dilator, held in the right, is introduced through the external os without much difficulty; but its progress is arrested at the internal os, where the obstruction generally exists. But steady, firm pressure exerted in the proper direction will usually overcome the obstruction, and the beak of the instrument jumps suddenly through the internal os. The shoulder on the blades limits the amount of penetration and prevents injury to the fundus. Where steady and firm, but gentle, pressure does not overcome the obstruction, I prefer to withdraw the instrument and pass successively applicators wrapped tightly with cotton, increasing the size until the dilator can be introduced without force. Harsh means cannot be too strongly condemned. I have never found it necessary to bore the external os with a pair of pointed scissors, and consider it a harsh and unnecessary procedure. Should an exceptional case present in which it was impossible to pass the probe, I should introduce a small laminaria tent and wait.

When the blades have been introduced as far as the shoulder, the handles are gradually brought together, the thumb screw being made to follow along and hold the advantage gained when the hand becomes tired, or the dilatation may be done with the screw alone. The amount of dilatation is usually

the full extent of the instrument (one inch), but this depends upon the case. After a few moments the screw is loosened and the instrument is withdrawn. The canal is then cleansed of mucus by means of applicators wrapped with absorbent cotton, and a hard-rubber bougie (Hawk's), No. 13 American scale (20 French), is gently passed, followed by successive sizes up to 18 if the case require it. After this, an applicator armed with cotton and dipped in liquid carbolic acid is passed through the cervical canal. A tampon of absorbent cotton saturated with the boroglyceride, fifty per cent. with glycerine, is placed against the cervix and the patient is transferred to the bed to recover slowly from the anæsthetic. Besides possessing antiseptic properties, the boroglyceride depletes the tissues and relieves irritation.

The stem used in the after-treatment is of hard rubber two inches long and slightly curved, having a cup-shaped shoulder which hugs the cervix and remains in position better than the glass stem I formerly used. It is tunnelled or perforated through the centre to allow drainage. There are three sizes, 10, 12, and 14 English, corresponding with sizes 13, 15, and 17 of the American scale. Its introduction is best accomplished by means of the sponge tent applicator, the end of which is made to fit in the perforation. By using this the stem can be introduced very nearly straight, even when there is considerable flexion. The curve in the instrument takes the place of the curve in the stem and allows the point of the stem to pass the angle in the canal with greater ease. By seizing the cervix on the side with a tenaculum, and pressing the stem firmly into the canal, carrying the handle of the instrument well back toward the perineum, its introduction is facilitated. In retroflexion the movement is reversed.

On the day following the operation the tampon is removed, the canal cleansed of mucus, and the hard-rubber dilators are again passed, after which the stem is introduced as described above and held in position by a similar tampon of cotton soaked with the boroglyceride. This is repeated every day, the stem being removed, cleansed, and replaced. After a week of this treatment, during which time the patient is confined to her bed, the stem is removed permanently and she is allowed to get up. In some instances the stem is introduced curved at first, and after the uterus has become accustomed to its pres ence it is straightened.

The conclusions arrived at are:

First. That rapid dilatation is a perfectly safe, justifiable, and satisfactory procedure, free from the dangers which frequently follow the cutting operations, especially the occurrence of cicatricial contraction.

Second. If the stem be used in the after-treatment, recontraction does not occur, and the operation does not require repetition.

Third. The operation is demanded by the following conditions: viz., (1) Marked stenosis with or without flexion. (2) Acute flexion without actual stenosis, the obstruction existing only coincident with menstruation. (3) Slight stenosis as shown by the passage of the sound, dysmenorrhœa and sterility existing without other cause. (4) Mild endometritis from acquired narrowing of the cervical canal and lack of free drainage for the discharges.—*Medical News*, April 3, 1886.

INHALATIONS OF COLD AIR IN TYPHOID FEVER.—DR. ALEXANDER M. SOKOLOFF, searching for some means of intensifying the antipyretic action of cold air, resolved upon undertaking a series of experiments on inhalation—that is, on introducing this cooling agent into the lungs, into "one of the regions of maximal heat-formation." His observations were made in twenty-three cases of enteric fever, five of which were of an abortive type, the remaining eighteen being moderately or very severe (two ended fatally). The patients were made to inhale from a Niemeyer's cold-air inhaler (*see* P. Niemeyer's *Aertzl. Spretchs.*, vol. vi., part 3, p. 129), slightly modified by the author. About 510 inhalations were made in twenty-three cases, the number of sittings in an individual case varying from six to forty-two; the number of sittings daily from one to three; the duration of a sitting from five to thirty minutes; and the temperature of the air from −2° to 10° R. From these observations the author draws the following conclusions:

1. Inhalations of cold air produce a greater or less depression of febrile temperature; but, contrary to the author's expectations, their effect is comparatively weaker and more fleeting than that of cold-water baths, and even of cold air baths. The antipyretic effect of the inhalations varies according to certain conditions. (*a*) *The time of the day.* The least decrease of the febrile temperature, varying from 0°.2 to 0°.5 C., is observed when the inhalations are made between noon and 6 P.M. The strongest effect, varying from 0°.5 to 1°.3 C. (after a single sitting), is observed between 7 P.M. and 10 P.M. (*b*) *The stage of the disease.* The slightest and shortest effects are observed during the two first weeks of enteric fever, when the average daily decrease (after several sittings) falls short of 1° C., and when the effect of an individual sitting does not last longer than one and one-half to two hours. During the next weeks of the disease the effects are stronger (often 1° C., after a sitting), and last several hours. (*c*) *The duration of the inhalation* is but of slight importance. A sitting of five to ten minutes' duration gives the same decrease of the febrile temperature as a sitting of twenty minutes' duration. [The author attempts to explain this rather strange circumstance by fatigue of the lungs, in consequence of which the patient makes accelerated and superficial respiratory movements.] At all events, the greatest antipyretic effects are obtained from sittings of twelve to fifteen minutes' duration. (*d*) *The temperature of the air inhaled.* A temperature of −2° or −3° R. gives almost the same decrease of the febrile temperature as the temperature of −4°, −5°, or −6° R. Relatively stronger effects are obtained from temperatures of −8°, −9°, −10° R. [It would seem natural to expect *à priori* that the antipyretic effect ought to be greater, the lower is the temperature inhaled. It proved, however, otherwise. The relatively small effect of lower temperatures is attributed by the author to a comparatively shorter duration of the sittings, the patients being unable to

perform prolonged inhalations on account of unbearable toothache occurring in consequence of intense cooling of the mouth and teeth.] (*e*) *The mental state of the patient.* Both depression and excitement (often observed in typhus patients) diminish or even entirely suppress the antipyretic effect of the inhalations.

2. The inhalations produce retardation of respiration (in average, four a minute) and pulse (in average, six beats a minute). At the same time, breathing becomes deeper, and the pulse fuller.

3. The inhalations relieve dryness of the mucous membranes and skin.

4. Inhalations of cold air promote resolution of the bronchitis which often complicates enteric fever, and increase the process of ventilation in the lungs.

5. Hence the inhalations lead to an improvement in the patient's general state, sleep, and appetite.

6. Inhalations of cold air act antiphlogistically on the inflamed respiratory tracts, and hence may be employed as a rational therapeutic agent in the treatment of pulmonary inflammation.

7. Systematic inhalations of cold air may prove of use also in chronic bronchitis, asthma, and emphysema.

[In the *Meditzinskoie Obozrenie*, No. 13, 1884, p. 12, Dr. V. F. Sprimon points to the disadvantage of the use of the cumbrous and heavy Niemeyer's inhaler, and advises a trial, in winter time, of inhalations of cold air conduced from a window through a piece of tubing, the patient inhaling the air by means of a mouthpiece from a Waldenburg's apparatus. In the *Vratch*, No. 14, 1884, p. 242, Professor V. A Manassein points out that Sokoloff's observations are important as a new illustration of the fact that cool air in itself is harmless to the febrile patient, and that the well-known fears entertained as yet by the public at large, and even by medical men, in regard to "chilling the patient" are entirely groundless. Like Sprimon, Manassein also finds any special cooling apparatus superfluous. Valuable information is collected in Dr. R. Neale's *Medical Digest*, sect. 257: 2.—*Rep.*]—*London Medical Record*, March 15, 1886.

Experimental Transfusion.—It is now generally recognized that many of the conditions in which the operation of transfusion of blood has been regarded as essential, may be successfully treated in other ways. Thus it is admitted that the collapse following severe hæmorrhage is due not to a loss of blood *per se*, but to a purely quantitive loss of fluid vascular contents—a loss which may be supplied by the intravenous injection of salt solution. Nevertheless, in spite of its dangers, occasions arise in which transfusion is indicated, and in view of the growing disfavor with which the operation is now regarded, much interest attaches to some recent experiments of Bizzozero and Sanquirico, recorded in the ninth volume of the *Arch. per le Scienza Med.*

In the dogs which were the subjects of these experiments, both the numerical proportion of the red corpuscles and the percentage of hæmoglobin were first ascertained. Blood in varying amounts was then withdrawn, and an equal quantity of defibrinated dog's blood transfused by the jugular vein. In periods of from fifteen minutes to eighteen days the blood of animals thus operated upon was investigated, and the results compared with those of the preliminary examination. In a second series of experiments, one-half of the total blood of the animals was withdrawn, defibrinated, filtered through linen and returned to the veins of the animals from which it was taken. This procedure was ten times repeated, so that each corpuscle of the animal was subjected approximately five times to this rough handling. Before and after this series of experiments the same close examination of the quantitative relations of corpuscles and hæmoglobin was instituted, with the result of showing that in no case, in either series, was a noteworthy effect produced.

These observations lead to the conclusion that not only is the red corpuscle remarkably resistant to rough treatment, but that the transfusion of the defibrinated blood of animals of the same species is not injurious.—*Medical News*, April 3, 1886.

Physiological Action of Antipyrin and Kairin.—Dr. S. J. Pavlinoff describes the results of some experiments as to the chemical and physiological properties of antipyrin and kairin.

Chemical Properties.—[The preparation of antipyrin was obtained from Ferrein, and presented an amorphous yellowish powder of pretty strong bitter taste, with aromatic flavor. It was soluble in water and ether; the solutions were neutral.] Kairin belongs to light oxydizable substances; its solutions, kept in contact with the air, within twelve hours become of a ruby color, and in a few days rich dark cherry-red. On the other hand, solutions of antipyrin remain unchanged (that is, either colorless or yellowish) for a month, or even longer. Being treated by nitric acid, kairin solutions turn to dark cherry-red, and, on being subsequently diluted, they gradually become yellow, the latter coloration occurring still even when only 0.001 per cent. of the drug is present. Antipyrin gives no reaction with the acid. But both kairin and antipyrin solutions assume a claret-red color on being treated by perchloride of iron ($Fe_2 Cl_6$).

Physiological Action.—A. *Blood.*—As Morokhovetz showed (see the *London Medical Record*, October, 1884, p. 421), when mixed with an equal volume of a 0.001 per cent. solution of kairin, the blood assumes a claret-red color, and gives the methæmoglobin bands on the spectroscopic examination. The red blood corpuscles take a cup-like form and brownish color. But antipyrin remains entirely inactive, even when a 1 per cent. solution is employed. The same difference between the two substances is observed, also, when intravenous injections of their solutions in dogs are undertaken. B. *Blood pressure.*—Antipyrin induces an increase of the arterial tension, while the latter is rapidly and very considerably lowered by kairin (after a fleeting initial rise). C. *Pulse*—Under antipyrin, the pulse becomes somewhat retarded, but its rhythm remaing regular; while under kairin it quickens and assumes a filiform character. Some experiments seem to point out that kairin affects the cardiac muscle, the cardiac nerve-apparatus remaining intact. On the contrary, antipyrin appears to act on

the latter, and to leave intact the former. *Respiration.*—Antipyrin produces a very considerable quickening of the respiration, the type of which, however, remains uniform all through. On the other hand, kairin brings about interrupted or irregular breathing. [Therefore, as far as circulation and respiration are concerned, kairin and antipyrin are endowed with diametrically opposite actions.] E. *Salivary Glands.*—Both of the drugs augment the secretion of saliva; antipyrin may be detected after a while in the latter, though in small quantities. F. *Pancreas.*—Neither antipyrin nor kairin has any influence on the secretion of pancreatic juice. G. *Liver.*—Kairin increases the secretion of bile, the color of which gradually turns to black, while antipyrin remains entirely inactive. H. *Kidneys.*—Neither of the drugs manifests any action on the quantity of urine. But the first portions of urine voided after the introduction of antipyrin contain a considerable quantity of the drug. [Therefore, antipyrin is eliminated from the system through the kidneys and salivary glands.] I. *Motor Nerves.* Dr. Pavlinoff confirms the statement of Morokhovetz that kairin, like curare, affects the intramuscular endings of the motor nerves (in frogs); the drug acts antagonistically to strychnine (as Professor F. P. Sheremetevsky supposed). Nothing of the kind is noted as regards antipyrin. J. *Reflex Action.*—Antipyrin increases the reflex action (as Professor Demme, of Berne, first proved). K. *Temperature.* Antipyrin depresses the normal temperature, but not at any uniform rate, the latter varying from 0°·5 to 2° C. and more; generally speaking, the depression is the more marked, the shorter are the intervals between the doses administered. Under kairin, the temperature sinks in consequence of the drug absorbing oxygen of the blood; hence, the use of karin in cases of pneumonia, chronic pulmonary disease, anæmia, cardiac disease, etc., is fraught with obvious and immediate danger. In all such cases, antipyrin may be safely and effectively administered, the drug being indifferent in its chemical behavior towards the blood, and if anything, strengthening the cardiac action.—*London Medical Record*, March 15, 1886.

DECOCTION OF LEMONS IN INTERMITTENT FEVER.—Having reviewed the literature of the subject (Maglieri, Stephens, Toropoff, Tommasi-Crudeli, Dominico Azzillo, Norman Forbes, Lauchlan Aitken, Putokhin), DR. NIKOLAI N. MASLENIKOFF proceeds (*Kavkazsky Meditz. Sbornik*, vol. 39, Fasc. ii, 1885, p. 29) to describe his own observations on twenty cases of intermittent fever, treated by decoction of lemons in the Military Hospital in Temïr-Khan Shura, Dagestan region. Seven of the patients were affected by the fever for the first time, three for a second; the remaining had passed previously through several malarial attacks. In thirteen of twenty cases a quotidian, and in seven a tertian, variety was present. In sixteen cases the spleen was found to be enlarged and painful (in fourteen, both during the paroxysms and the intervals). The decoction was prepared after Maglieri's method, that is, every evening a whole fresh lemon was cut into very thin slices, put into eighteen ounces of distilled water in an earthen pot, and boiled (for two hours) until six ounces of decoction remained. On the next morning the liquid was forcibly strained through a piece of gauze, and then given to the patient to take immediately at several gulps. The decoction was used in that way for ten or fourteen successive days. In none of the patients did any gastric disturbances occur. The results obtained by Dr. Maslennikoff were not so successful as those by Dr. Putokhin. In only six cases, four of which were of quotidian fever and two of tertian, a cessation of paroxysms ensued. In two of the remaining patients, the paroxysms became less severe; and in three the type of fever underwent a change. In none did any alterations in size of the spleen take place. All cases where decoction of lemons had failed were subsequently, mostly very rapidly, cured by quinine. The general conclusion reached by the author is that, as far as severe Caucasian fevers are concerned, decoction of lemons has, except its agreeable taste and harmlessness, no advantages whatever over other substitutes for quinine.—*London Medical Record*, March 15, 1886.

HEPATIC ORIGIN OF UREA.—DR. D. W. AITKEN, describes, in the *British Medical Journal* of February 6, 1886, the following interesting case, the direct bearing of which upon the question of the source of urea is evident:

Early this month (January) I was called to see a boy who had the day previous received a rather severe blow upon the right lobe of the liver. When seen he was complaining of much pain in the right hypochondrium. The skin was slightly, and the conjunctiva distinctly jaundiced. The stools were pale, while the urine was bile-colored, and gave the bile reaction with nitric acid; there was no fever. But herein lies the important matter. The urine was highly alkaline. On the addition of nitric acid there was such violent effervescence that the froth was forced out of the test-tube, although the urine was not much more than one inch deep. I got my friend, Dr. Drinkwater, to examine the urine carefully. He reports that the alkalinity was due to ammonium carbonate, and, on estimating the urea, he found only three per cent.

This evidence seems to point strongly to the liver as the seat of production of urea. Dr. Graves has already reported several cases of absence of urea which he believed to be represented in the urine by the ammonium carbonate, but here we have a history of the organ involved.—*Medical News*, April 3, 1886.

A MICRO-ORGANISM IN THE TISSUES OF HEREDITO-SYPHILITIC CHILDREN.—KASSOWITZ and HOCHSINGER have found micro-organisms constantly in five syphilitic children, occurring in the skin in pemphigus, in the liver, and in bone-tissue. They are streptococci, arranged in chains. The authors have never found Lustgarten's bacilli. The micro-organisms found occurred in the fine capillaries.—*St. Petersb. Med. Woch.*, No. 11, 1886.

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THE EDITOR OF THIS JOURNAL would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the writer's full name and address, although not necessarily to be published. All communications in regard to editorial work should be addressed to the Editor.

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IN WHAT PLACES SHOULD THE ANNUAL MEETINGS OF THE AMERICAN MEDICAL ASSOCIATION BE HELD; AND WHAT ARE THE NECESSARY LOCAL EXPENSES CONNECTED WITH SUCH MEETINGS?

These are questions of sufficient importance to demand more attention than they have hitherto received. To prevent the membership and the influence of the Association becoming too much restricted within narrow limits, and to secure the stimulating influence of these meetings upon the formation and support of State and local societies in all parts of the country, a constitutional provision was adopted prohibiting the holding of two annual meetings in succession in the same place. Consequently the general policy has been to have the annual meetings alternate from one section of the country to another, depending much upon such invitations as might be extended by the local profession in different cities. While the leading objects sought to be accomplished by holding the meetings in different parts of the country were actually attained, and the social organization of the profession in the different States was rapidly advanced, some evils were developed which have never been obviated.

It was found that the income of the Association was made to depend much upon the size and location of the city in which the meetings were held. When a meeting was held in any of the great cities surrounded by States in which the profession was well organized, the number in attendance was large, and the income from the payment of membership dues was correspondingly large; but when the meeting occurred in a smaller city, or even in a large city not surrounded by populous States in which the profession was well organized, the number was small and the income small. For although the annual membership fee was due from all permanent members whether attending the annual meetings or not, yet the Treasurer's reports show that comparatively little was actually paid except at these meetings. While the Transactions of the Association were published in a single volume yearly and distributed from six to nine months after each meeting, the amount actually collected from permanent members not at the meetings was so small that the number losing their membership from non-payment of their dues came to be nearly equal to the annual addition of new members.

Since, instead of one annual volume, each member receives a valuable medical journal each week, the financial evils just mentioned have greatly lessened and the annual income from membership dues has doubled. And yet so apparent are the advantages of a meeting in a large city in the centre of populous States and well organized State Societies, both in securing the addition of new members and larger revenues, that careful attention should be given to the subject by each nominating committee. Another evil of greater magnitude developed early and increased rapidly in connection with the practice of meeting successively in different sections and on direct invitations from the profession of different cities in which the meetings were held. Naturally, when the profession of a city extended an invitation to the Association to hold the next annual meeting there, they assumed the responsibility of furnishing all necessary accommodations for the meeting at their own expense, as well as the additional expense of what hospitalities in the way of banquets, entertainments, etc., might be provided.

At the first two or three annual meetings the hospitalities were cordial, but of a private or individual character. But at the third annual meeting, which was held at Boston, in 1849, one evening was set apart for a general social melee or promenade in a public hall for the laudable purpose of affording more direct social intercourse of members from all parts of the country. With genuine good taste the local committee provided no other refreshments than coffee, simple cakes and fruit, on a side table where any one who wished could partake when they pleased. But this simple and very pleasant example was quickly converted into the form of a "public banquet" which each subsequent local Committee of Arrangements endeavored to make more magnificent and costly than their predecessors, until at New York, in 1853, the banquet alone was said to have cost more than

$10,000; and the next year at St. Louis its extravagance and the excesses accompanying it, led to the adoption of a resolution offered by the late Professor S. D. Gross, forbidding all subsequent Committees of Arrangements to provide any public banquet in connection with the annual meetings of the Association. This checked the evil in that direction, and still the rule was often evaded by accepting banquets tendered in the name of the citizens instead of the local profession, and costly entertainments and private receptions multiplied, not only sufficient to constitute a heavy tax upon the local profession, but also to so completely occupy all the time intervening between the necessary sessions of the Association and the Sections, as to leave hardly an hour for special committees to do any work that might be assigned to them, or for fatigued members to obtain a much needed rest.

It was to still further lessen these evils, that in 1867 a rule was adopted that each alternate annual meeting should be in Washington, the Capital of the country, and the strictly necessary expenses for rooms to accommodate both the general sessions and the Sections, and the printing of programmes for all future meetings, should be paid from the treasury of the Association, thus relieving the local profession from all strictly necessary expenses for the annual meetings. Nevertheless, wherever an invitation has been accepted to meet in any city, the parties giving the invitation have continued the practice of filling every evening with an excess of expensive entertainments or receptions, and sometimes crowding excursions into a part of the last day of the meeting. We think the time has come when reliance upon invitations to meet in one city or another should be abandoned and the selections should be made with reference to securing the largest increase in the membership, and as far as possible strengthening the State and local organizations in all parts of the country. Inasmuch as the Association pays for all the necessary accommodations and printing for each meeting, there should be no direct or implied money tax on the local profession at the place of meeting, but only the services of an efficient Committee of Arrangements. In all the great cities there are wealthy citizens both in and out of the profession who would deem it a pleasure to give receptions enough to occupy one evening, and if any considerable number of the members of the Association desire a social dinner or banquet, it should be provided at their own expense and under their own supervision, as is the case in the British Medical Association and in similar organizations in other countries.

MOOT POINTS IN SYPHILIS.

When, a few months ago, it was announced that MR. JONATHAN HUTCHINSON, the Lettsomian Lecturer of the Medical Society of London, for 1886, would lecture on "Some Moot Points in the Natural History of Syphilis," dermatologists, syphilographers and surgeons generally were on the *qui vive* to see how the subject would be treated by the generally acknowledged master pathologist and surgeon. American surgeons and dualists were quite prepared for an opening shot at dualism, but few, we think, were prepared to read the following: "A dualist is, I suppose, one who holds that there exist two quite distinct and independent cartagia, one of which produces a non-infecting sore, and the other syphilis." Under the circumstances of place and subject it seems that the lecturer should at least have been entirely familiar with the ground of the "the opposition;" the more especially since in the next breath he begins to discuss the question at issue.

Beginning with a series of hypotheses, and a play upon words as to the difference between "specific contagium and specialized contagium," the lecturer built up a very pretty argument in favor of unicity—but one in which the facts of Basserau, Diday, Rollet, Fournier, Coby, Ricord and, not to make the list too long, Pick, Kraus, Reder, Henry Lee and Morgan (quoted by Mr. Hutchinson in support of unicity), Wigglesworth and R. W. Taylor are to all appearances utterly ignored. Equally surprising is the fact that so good a pathologist and so close a student seemingly forgets the pathological differences between the chancre and the chancroid. Can it be that the "specific contagium" of the one produces cell-proliferation, while the "specialized contagium" of the other causes distinctive metamorphosis? In the face of the mass of evidence to the contrary Mr. Hutchinson says: "So far as I can see, all *a priori* probability favors the suggestion that non-indurated sores are produced by the secretion of true chancres, which have been changed in character either by the inflammatory process, or by the non-susceptibility of the tissues of the recipient." In that portion of his first lecture in which he discusses this question the only names mentioned are those of Danielson, Lee, Morgan, Gascoyen and Bidencap. The conclusion of Bäumler that "the chancroidal poison cannot even be compared with the syphilitic poison, to say nothing of regarding them as identical," appears to have escaped notice.

Few surgeons in this country or on the Continent, we think, will agree that "scars in the groin are presumptive evidence of syphilis." We must know how

the patient was treated for the sore which preceded the bubo, and whether, as is sometimes the case with chancroidal buboes, the glandular trouble appeared after the primary sore disappeared. But apart from this Mr. Hutchinson is certainly at variance with authorities in holding this view. The best authorities are agreed that the syphilitic bubo usually terminates by resolution, while the chancroidal is inclined to suppuration. There is, therefore nothing remarkable in Mr. Hutchinson's experience of having never seen a suppurated bubo in the armpit in association with chancre of the finger. We neither see anything remarkable in this fact, nor can we agree with him that it indicates that the "soft sore but rarely causes bubo"—an inference which he draws. If it be his observation that "it is not very exceptional for the typical chancroid to cause no enlargement of the glands at all" his experience must be exceptional; and broad general deductions should not be drawn from such an experience. With such views as to the nature and pathology of the chancroid we are prepared for an announcement that phagadæna is as frequent a sequence of chancre as of chancroid, but scarcely for the sweeping statement that "all will admit that syphilitic inflammations have a remarkable tendency to become phagodænic," unless the chancroid be classed as a syphilitic inflammation. Nevertheless, within a page of the statement just quoted he says that it is a question whether the infecting or the non-infecting sore is the more liable to phagadæna.

We can agree with the lecturer that too much importance has been attached to induration of the chancre as a symptom of syphilis. Induration may be entirely absent, or it may vary widely in degree and duration. Chancrous induration is not altogether so common, in the opinion of the best authorities, as glandular induration. Mr. Hutchinson thinks, however, that we must therefore come to the conclusion that "syphilis can begin without any induration whatever." He does not think it very probable that an intra-urethral chancre may occur without pain, without signs of obstruction, and without external induration or discharge; but this is certainly as probable, if not more so, than that syphilis can be introduced into the system without any abrasion. In connection with such cases he refers to those in which a patient has a urethral discharge, simulating gonorrhœa, or gonorrhœa itself, and in which syphilis, without the detection of a chancre, follows. We cannot believe that there is any good reason for terming such cases "gonorrhœa-syphilis" because the affections are at first coincident. It should be remembered that the urethral discharge is by no means necessarily gonorrhœal. In a case of true gonorrhœa, as Mr. Hutchinson suggests, the acute urethral inflammation may act in preventing the local adhesive inflammation of the chancroid, and this is a much more tenable hypothesis than that the syphilitic virus is absorbed directly, without any sore at all.

We may pass over the remarks on rupia and psoriasis palmaris, syphilitic lupus, periostitis and other symptoms commonly classed as tertiary, but which are not strictly confined to that period, and notice what the lecturer has to say of the influence of mercury as antidote. His remarks on this subject should be read by every one who is partial to large doses of this drug in the treatment of syphilis. Indeed, since we know that small doses of mercury increase the number of red blood-corpuscles, and that large doses diminish the number, it seems strange that anyone should now advocate or administer large doses. Recent experience, says Mr. Hutchinson, has much strengthened the claim of mercury to rank as an antidote to the virus of syphilis, and the fact is "one of extreme importance in reference to a very important department of general pathology and therapeutics. In connection with it we may suitably bear in mind the great repute which weak solutions of corrosive sublimate have recently obtained in the prevention of septic processes." The form of mercury which he has used almost exclusively is the gray powder, in one grain-doses, from three to six times in twenty-four hours, and seldom for a shorter time than six months in the first instance. "If this dose be given to a patient with an indurated sore, but in whom, as yet, no secondary symptoms have appeared, the result will usually be that none will occur." Neither the preparation of mercury used nor the time of giving it will be endorsed, we think, by the majority of syphilographers, The weight of authority is certainly against the administration of the drug before the appearance of constitutional symptoms (save in exceptional cases). Otherwise it is entirely probable that a patient may take it for some months, and have much mental anxiety, when he has only had a chancroid. He admits that the grey powder is the "most convenient" form, but syphilis is a disease in which we cannot always consult our convenience. The evidence seems entirely sufficient to show that the course of a case is not affected by delaying the mercurial treatment until constitutional symptoms appear.

The third lecture is devoted entirely to questions concerning the inheritance of syphilis, and it is in this particular field that Mr. Hutchinson has done some most excellent work. The points discussed in the lecture are as to transmission to many children in

succession, the supposed connection between syphilis and rickets, ulcers of the palate and pharynx in young persons, malformation of joints in consequence of infantile syphilitic periostitis, ringworm of the tongue, possibly sometimes connected with hereditary syphilis, chronic skin diseases due to hereditary syphilis, diseases of the nervous system, and idiocy in connection with inherited syphilis. As already stated, his work in the way of elucidating problems in hereditary syphilis is monumental, as may be seen in the almost unparalleled article on "Hereditary Syphilis," by Dr. J. William White, in Pepper's "System of American Medicine." We could wish that much more time could have been given by Mr. Hutchinson to the questions discussed in the third lecture. A full discussion of these questions could very properly have taken up two lectures, especially had those spoken of in the first been omitted altogether.

ARTIFICIAL RESPIRATION AND STILLBIRTH.

In the *American Journal of the Medical Sciences*, for January, 1886, MR. FRANCIS HENRY CHAMPNEYS, of London, has a most instructive article "On Some Points in the Practice of Artificial Respiration in Cases of Stillbirth and of Apparent Death after Tracheotomy." Before entering into a consideration of the subject proper, however, he rightly draws attention to the fact that "deadbirth" and "stillbirth" are not synonymous; for while all deadborn children are stillborn, all stillborn children are not deadborn. "A child born alive but 'still'—that is, generally, but not necessarily, with its heart beating, but without movement—may be in one of two stages or states, for the description of which we are indebted to Cazeaux. In the first, which he calls the 'apoplectic state,' the surface is livid, but the muscular tone is not lost, and there is no response to reflex irritation. In the second, which he calls 'syncope,' the surface is pale, the muscular tone is lost, and there is no response to reflex irritation. These two stages are also known as the livid stage and the pale or flabby stage of asphyxia."

The length of time which apparently dead children sometimes survive is remarkable, and the authenticated cases show that the greatest caution should be used to guard against premature burial or autopsy. The prognosis in cases of stillbirth, says Mr. Champneys, is of the utmost importance as a guide to treatment, but is usually not made. "The certainty of death in the cases of fresh children depends on the certainty of the cessation of the heart's action during a considerable period, for the heart may cease to beat for a time, apart from absolute death. In such a case, when the heart has ceased to beat for a considerable time (say ten to fifteen minutes), it might be well cautiously to insert a needle into its apex, before abandoning all efforts at resuscitation." As regards how long attempts at resuscitation should be persisted in on the sole ground of continued action of the heart, he thinks that if no attempts at spontaneous breathing occur within an hour, and especially if the heart act with diminishing force and frequency, in spite of the attempts at artificial respiration, the prognosis is hopeless. Upon the diagnosis of the state of asphyxia depends the second point in the prognosis, it being usually favorable in the livid stage, as this stage has the advantage of retaining reflex irritability. "If the heart is beating fairly, it is often sufficient to lay the child on its face, wipe out its mouth, and rub it along the spine, a far better way of exciting an inspiration than slapping the nates." But the prognosis is far more serious in the pale or flabby stage, and depends on the ability of the accoucheur to raise the child from the condition of flabbiness and induce a condition of reflex irritability. "Until this is done, all rubbing, slapping, bathing, etc., are simple waste of time. While the heart beats regularly, we may still hope for recovery up to a reasonable length of time. An important element in prognosis is the state of the pupils: they are widely dilated in asphyxia, but at once contract when respiration is properly established.

En passant Mr. Champneys has a word for those who tie the cord early. "It appears that a child gains some four to six ounces of blood after birth, the principal object of which is probably to furnish an additional supply for the newly established pulmonary circulation. This blood is not forced into its body so much as drawn into it by the first inspiration. . . . . In ordinary cases, therefore, it is best to tie the cord late . . . unless manipulations are indicated which require the child to be free from its mother." The usual advice that half an ounce or an ounce of blood should be allowed to escape from the cord in cases of livid asphyxia is probably founded on the livid appearance of the child. "The child, however, has *less* blood than it should eventually have, and has no more than a child in the pale stage, the difference being one in the distribution rather than the amount of blood."

In artificial respiration four objects are aimed at: removal of foreign bodies from the air-passages; procuring the patency of the air-passages; excitation of the circulation; ventilation of the lungs. The best method of removing foreign bodies from the air-

passages is, according to our author, the following: Lay the child on its back, with the head hanging over the edge of a table, a little lower than the rest of its body. Wipe out the mouth with a soft handkerchief. Press the thorax gently with one hand, stroking the trachea upwards with the other, and retain the finger at the top of the trachea until the next movement is complete. The mucus will gravitate towards the posterior nares. Put a handkerchief over the child's mouth, blow gently, and the mucus will be blown out of the nostrils, but not into the operator's face. Should there be a large accumulation of mucus in the air-passages, a No. 9 elastic male catheter should be introduced into the trachea, so that the point is three and a half inches from the lips, which will secure its passage through the glottis, but not to the bifurcation of the trachea. Press the thorax gently with one hand to prevent the entrance of air, and blow through the catheter. In this way the mucus will be blown into the pharynx, as the compression of the thorax with the hand prevents it being carried into the lungs. "This manœuvre is more efficient and far pleasanter than the suction usually recommended; it has answered well in practice."

For securing patency of the air-passages, exciting the circulation, and ventilating the lungs, Mr. Champneys thinks that Schultze's methods of artificial respiration accomplish them better than anything else (though for exciting the circulation pressure of the hand over the præcordium has an effect in raising the blood-pressure and exciting the action of the heart, and is a chief reason for the success of the methods of Howard and Hall). The only two trustworthy methods for ventilating the lungs are those of Schultze and of Silvester (with the modifications of the latter by Pacini and Bain). As these methods and modifications have been known for more than a decade it seems unnecessary to give them in detail in this place. Silvester's method does not imitate the natural breathing of the child, which is diaphragmatic, while in Schultze's methods the diaphragm is made to descend slightly. Though his method has the disadvantage of being somewhat more violent than the others (which can be in a measure controlled by the operator), it has the two advantages that in the expiratory position the child is inverted, and gravity assists in removing mucus and other substances from the air-passages; and that in some cases it really provides patency of the air-passages when other methods have failed. In case it be desired to practise direct inflation of the lungs, the operation may be made clean by laying a towel over the child's mouth and breathing through it. The asserted danger of rupturing the lungs may be averted by gentleness and leaving the nose free. The imaginary danger of inflating the stomach need not be discussed.

As regards the action of heat and cold Mr. Champneys has but little to say, but that little is entirely to the point: "It has been proved that, within limits, the lower the temperature the longer can an animal survive without breathing, and the higher the temperature the more quickly it dies. To keep a child in a hot bath until respiration is established is, therefore, a wrong practice. The hot bath can, however, be used in alternation with the cold bath, but merely as a means of increasing the effect of the cold bath, and in the pale (flabby) stage of asphyxia this also is useless. Under such circumstances it is best to wrap the child in a warm flannel, and not to waste time on baths, but to proceed at once to the establishment of respiration." The treatment advocated in this admirable paper is summed up as follows: Never hurry; it is not a question of seconds, and success depends upon a fine exercise of the judgment. Make a good diagnosis, first, as to life or death, second as to the stage of asphyxia (if life is not extinct). If the child be macerated, it is obviously dead and past hope. If the heart beat, ever so slowly and feebly, it is not dead. If the heart be not beating, death is not certain, unless it can be proved to be inactive for some time. If the child is livid and not flabby, it will probably come round; wipe out its mouth and pharynx, and rub it with a soft cloth down the spine, press gently on the cardiac region. If this produces no effect, inflate the lungs by the mouth, and then by Silvester's method. If air enter the lungs, well and good; if not, try Schultze's method, or insert a catheter, as described above. On the first sign of muscular action, plunge the child into cold water, or into alternate cold and hot baths. Vary the treatment between occasional inflation of the lungs, artificial respiration, pressure over the cardiac region, baths, irritation down the spine, according to the judgment; remembering what may be expected of each method, and that no one will suffice for all cases. Watch for signs of resuscitation, namely, improvement in the color, in movements, in cardiac pulsations, as described above. Never be content until the child breaths regularly, and appears to be continually improving.

STATE MEDICAL SOCIETY OF ARKANSAS, CHANGE OF PLACE OF MEETING.

The president, W. H. Hawkins, M. D., and the secretary, L. P. Gibson, M. D., of the State Medical Society of Arkansas, have sent out the following cir-

cular regarding the change of place of meeting of the Society:

"On account of the terrific fire and cyclone that have afflicted Helena, and the probability of an overflow cutting off communication with that city about the time of the meeting, the committee of arrangements has given notice that it would be advisable to change the place of meeting. Therefore the eleventh annual session of the State Medical Society of Arkansas will be held in the Council Chamber at Little Rock on Wednesday and Thursday, April 28 and 29, 1886, commencing on Wednesday at 10 a. m.

"It is of the greatest importance that members who intend to read papers will send the titles of the same to the secretary at once, so that a complete programme can be prepared.

"Questions of grave importance to the medical profession, not only of Arkansas but of the whole nation will be considered, and every member ought to attend and induce others to come and join the society.

"Arrangements have been made for reduction of fare on the railroads."

A BILL FOR AN ACT TO REGULATE THE PRACTICE OF MEDICINE AND SURGERY IN THE STATE OF IOWA has recently passed the Legislature of that State and become a law, though its penalties are not to be enforced until January, 1887. The law is similar in many of its features to the well known Illinois law for regulating the practice of medicine and surgery. The Bill in full may be found in the department of State Medicine in this week's issue of THE JOURNAL.

THE ADDRESS IN MEDICINE BEFORE THE BRITISH MEDICAL ASSOCIATION.—It is announced that DR. J. S. BILLINGS, U. S. A., has been selected to deliver the Address in Medicine before the next meeting of the British Medical Association, in place of the late Professor Austin Flint. The well known ability of Dr. Billings and his familiarity with general medical literature, makes the selection one eminently proper.

DEATH OF A MEDICAL STUDENT.—MR. GEORGE A. COOK, a student of the Chicago Medical College, died April 8, 1886, at the residence of his father, Dr. E. P. Cook, in Mendota, Ill., of pneumonia, aged 21 years. He was a good student and a young man of much promise.

MEDICAL LEGISLATION IN OHIO.—A note from Dr. R. Harvey Reed, of Mansfield, Ohio, informs us that a Bill establishing a State Board of Health has passed both branches of the Ohio Legislature and become a law. We have not as yet any details of the Bill.

SOCIETY PROCEEDINGS.

SUFFOLK DISTRICT MEDICAL SOCIETY.

SECTION FOR CLINICAL MEDICINE, PATHOLOGY AND HYGIENE.

Stated Meeting, March 10, 1886.

F. I. KNIGHT, M.D., CHAIRMAN.

ALBERT N. BLODGETT, M.D., SECRETARY.

The first work of the evening was the presentation of lantern-slides, by DR. H. O. MARCY, containing

PHOTOGRAPHIC VIEWS TAKEN FROM MICROSCOPIC PREPARATIONS OF THE VARIOUS BACTERIAL FORMS FOUND IN THE COMMUNICABLE DISEASES,

as well as a series of preparations showing the impurities contained in the atmosphere, in water, in clothing, etc.

DR. CUSHING being called upon by the Chairman, remarked that he had nothing to say other than he had recently said before this Society in a paper upon an allied topic. One thing is becoming more and more evident, and that is the great and increasing degree of importance which is to be attached to the various forms of bacterial organisms, both as causes of, and factors in, the origin or the course of a large and increasing list of diseases. It is an undeniable truth that these lower forms of growth are associated in many ways with the health of the human subject, and the degree of weight to be attached to their presence cannot be overestimated. The technical difficulties attending the study of these organisms in their relations to human health have been, and still are, greatly magnified, and the processes of their preparation and preservation made unnecessarily obscure. There is no difficulty in the successful study of bacteria; any careful person can fully and completely understand the technique, and easily carry out the details of an examination of the animal tissues or secretions in relation to the presence or absence of disease germs. Test tubes may be thoroughly sterilized in the kitchen oven, and a culture chamber may be made from two soup-plates placed one upon the other. An even-temperature oven may be made from a wash-boiler, and the entire process may be so simplified that any good microscopist may be able to carry it out. Septic bacteria are easy to cultivate and to examine. As we become familiar with the processes of culture, and realize that a single touch of a needle is sufficient to infect an aseptic culture, we form a better comprehension of the great importance of absolute cleanliness on the part of the surgeon, who may easily carry fatal infection—a veritable death-sentence—beneath his finger-nail. When a patient with a surgical disease takes cold in the

wound, we now look for the signs of some septic contamination as the cause, and frequently find that absolute cleanliness will put an end to all the untoward symptoms.

Dr. Goodwin said that he had made some rather exhaustive studies in the department of bacteriology, and had had the common experience, that the ordinary means of illumination are quite insufficient for the purpose of detecting these small and refractory bodies.

He thought to buy an Abbé condenser, but found that it would cost here the sum of thirty dollars, which seemed too much to devote to one piece of accessory apparatus. Dr. Goodwin therefore obtained two ordinary plano-convex lenses of about 1½ inches focal distance, and mounted them in metallic rings. These were now adjusted to each other so as to form almost a double convex lens, and are so adapted to the sub-stage of the microscope as to act as a sub-stage condenser. The surface of the upper lens is now ground at its centre so as to form a horizontal area of about one-half inch in diameter; the entire remaining ovoidal surface is rendered opaque by gently roughening it with a corundum strop, and the instrument is ready for use. With this means of illumination, Dr. Goodwin has been able to secure unusual power of penetration and definition, and has found that some forms of bacillary organisms are clothed with a pellucid envelope or capsule, which he has not seen mentioned by any other observer, in relation to these bodies.

Dr. W. N. Bullard read a paper on

CHRONIC TEA POISONING.

I desire to-night to draw attention to an affection which from its great frequency, the peculiar discomfort of its symptoms and its relative curability, is worthy of the careful consideration of the profession. At first sight it may seem surprising that so little has been either written or spoken in regard to this subject, but I believe this to be principally due to two causes, firstly, the apparent ease with which any symptoms thus produced could be checked, by withdrawal of the existing agent, and secondly, to the indefiniteness and obscurity of these symptoms and the difficulty of proving their origin. During my study of this subject I have become more and more convinced that the latter difficulty is our greatest obstacle to a thorough knowledge of this affection, and that it is only to be overcome by the most careful investigation of each individual case and by the comparison of statistics drawn from a considerable number of such cases.

In the literature of this subject, which is curiously scanty and much of which has been written by the laity or from a non-professional point of view, I have been able to find only general statements, but few definite proved facts and *no* statistics.

In this paper we desire to confine our consideration to the cases of ordinary sub-acute and chronic tea-poisoning, putting aside all acute cases, where large quantities of tea have been imbibed at a single sitting and all those of tea-tasters or persons by profession exceptionally exposed to its toxic influence. In both these classes the symptoms are plain and well-known, and Morton's paper on tea-tasters leaves little more to be done in that direction except by those having special opportunities. The cases which I wish to consider are of the sort which present themselves daily to the general practitioner with symptoms sometimes obscure, and sometimes more or less pronounced.

The first fact which strikes the observer is the very gradual and insidious growth of the symptoms, which at first are frequently so slight and so indefinite as to be scarcely noticeable and only produce serious discomfort after a considerable period. This is one cause why their origin is not recognized by the patients themselves, and another reason for this may be found in the fact that the majority of them are of so general a character that they can readily be referred to some other source. Hence arises the difficulty in diagnosis, which so frequently occurs, and there are many cases in which it remains impossible to determine how far certain symptoms are the result of tea and how far they are due to other causes. As the cases become more severe the symptoms become more distinct and the diagnosis easier.

I will first describe a few cases of typical tea-poisoning and then proceed to the analysis of the symptoms.

Case 1. Boston Dispensary. Thomas G., about 55 years old, a horse-car washer. Complains of "rolling in the stomach" followed by flatus and tenesmus and has attacks of cold chills and weakness with a tendency to faint. He has staggered several times and come near fainting while at work, but has never fainted away. Has lost flesh lately. No palpitation; no cough. Drinks from one to three pints of tea per diem. He is emaciated and has a cachectic appearance. The heart and lungs are normal, so far as can be detected, except that the second sound is accentuated in the region of the pulmonary artery. Urine is normal in appearance, contains no albumen. Patient has lumbago and probably hæmorrhoids.

Case 2. Carney Hospital. Women, 40 years old. Diagnosis, "tea-dyspepsia." Patient is markedly nervous. She feels excited "as if afraid of somebody," especially when in a crowd. She used to have vertigo, but has never fallen. For two years she has been subject to distress in the epigastrium, palpitation, constipation, a dull heavy headache and dizziness, no cough. She drinks tea three times a day and also between meals.

Case 3. Woman 23 years old. Diagnosis, "tea-poisoning; anæmia." This patient applied at the Carney Hospital Out Patient Department on March 19, 1885, on account of bilateral headaches, frontal and occipital, accompanied by nausea and vomiting, which had occurred once a week for the preceding six months. She had been subject to these previously, but they were less severe and for about two years had been entirely absent. Her appetite was poor and she had a feeling of "weakness" in the epigastrium, but there was no distress after food, bowels regular. Had palpitation. Had never had rheumatism. Drank tea three times a day and also between meals. Under proper treatment she reported herself well on the 2d of April.

Case 4. Girl 13 years old. Complains of pain in both sides, especially the left, nausea, but no vomiting, headache frontal and bilateral, palpitation and dyspnœa. Bowels constipated. The heart and lungs were normal, as far as could be detected. There was some tenderness over the epigastrium. Drank one to one and a half cups of tea three times a day. This is a typical case of light tea-poisoning.

Case 5. Woman 60 years old. Dull frontal headache followed by "numbness" all over, which seems to be a sensation of weakness rather than a paræsthesia. Attacks of dizziness, when she fears that she will fall. Appetite poor. No vomiting, but nausea with the headache. Bowels regular. Drinks pure black tea strong three times a day and occasionally between meals. Distinct improvement in a week under treatment.

DR. HENRY I. BOWDITCH said that this paper is a most useful and instructive contribution to what we knew only somewhat distinctly concerning the effects of tea, when its use has been persisted into such an extent as to produce true toxicological results. Dr. Bowditch has very decided views on the subjects of coffee and tobacco, but he has not so frequently observed the deleterious action of tea. The Chinese in the tea-growing regions of the Flowery Kingdom take their tea in a manner very different from that to which we are accustomed. The infusion is not so strong, being made of such a concentration that the bottom of the tea-cup may be plainly seen through the infusion. They use neither sugar or cream in the tea, and Dr. Bowditch has found the flavor vastly improved by discarding these additions to tea as usually taken in this country. All these substances are nervous stimuli, and all are capable of injurious influence upon the nervous system.

The action is of the same nature as the stimulation from alcohol; but the effect is somewhat different, owing to the difference in the manner of taking the two substances, and probably too, owing to a difference in the particular mode of action of the substances. Dr. Bowditch related the case of a prominent politician, who was expected to appear and speak on a certain occasion, but who found himself quite unfitted mentally and physically to undertake the effort. However, by the aid of a quantity of strong tea, he was able to keep his engagement, and to make a long and brilliant speech without betraying the signs of uneasiness or exhaustion.

When the system is once saturated with either tea or tobacco, and the deleterious effects of these substances are once induced, there is nothing to do but to discard the articles at once and completely. Nothing but "total abstinence" will be of any avail. In Dr. Bowditch's personal experience, he found that after once being saturated by coffee, a period of abstinence of fifteen years was not sufficient to remove the effect, but the moderate indulgence in coffee after this long interval was followed by the immediate reappearance of the original symptoms, on account of which the beverage was originally discarded. Dr. Bowditch has never heard a paper which so fully analyzed and so clearly explained the action of tea, as the work of the present author has done.

DR. C. P. PUTNAM remarked that many physicians see patients in whom the influence of tea is plainly evident as a cause of depreciation of the general health. Dr. Putnam has seen many children, as well as adults, who were suffering from the effects of tea. Frequently the diagnosis is a matter of great difficulty; and in obscure and puzzling cases it is not to be forgotten that the abuse of tea may be the sole cause. One frequent symptom is that of ill-defined distress, or at times actual pain, in the region of the heart or stomach, or in some other part of the abdomen, with constipation, which is proved to depend on the abuse of tea, and disappears upon the discontinuance of the harmful agent.

The tea must be entirely withdrawn, as a small amount is sufficient to keep up the trouble.

DR. MARCY stated that he had had two cases of tea-tasting. One of these was a famous case. The patient was well known in Boston as a celebrated tea-taster and confidential buyer for a well-known tea house. This patient died, and at the autopsy many gummous deposits were found distributed through the various organs of the body. The patient had syphilis of Chinese origin. Another man was in business in Boston. He was habituated to tobacco, smoking fifteen cigars daily. He was also a tea-taster, but never was affected by any symptoms referable to the tea. Servants are fond of tea, and take it at all times of day, keeping the teapot on the fire all the time, and drinking from the dregs in the teapot. The value of tea as a beverage is in its aroma, the dregs furnish a bitter, astringent and unpalatable infusion.

DR. BULLARD stated that it is very hard to form a correct estimate of the amount of tea which is taken. This is particularly difficult in regard to servants, who are apt to underestimate the quantity they drink.

DR. WEEKS asked in how large a proportion of cases it is possible to persuade the victim to give up the use of tea.

DR. SCHOFIELD said that the children of those who make large use of tea, and give it to their children, are often the subjects of obscure symptoms referable to the heart, which disappear on stopping the tea.

DR. E. W. CUSHING stated that tea and coffee are much alike in one respect, from the fact that both contain a large amount of tannin, which is fully capable of causing a portions of the symptoms described, and may be the origin of a part of the trouble. If tea were made in the manner employed in China the tannin would not be taken, and this element of disturbance would be removed. Coffee may be prepared so as to deprive it of the tannin it contains, and it is then well borne, even by children. It may be best made in this way: Figs are taken as they are imported, and are baked so as to be of a brown color, and of taste and smell like caramel. A portion of such prepared fig is boiled in the water; after boiling for a few minutes the coffee is added and prepared as usual. Then an equal quantity of milk or cream is added and the coffee is served. Coffee thus prepared consists of infusion of fig, some coffee and a good deal of milk.

DR. GOODWIN said that the tannin content of tea

and coffee is so great that the tincture of chloride of iron cannot be given at the same time on account of the formation of ink in the stomach, and the consequent nausea.

Dr. Eastman remarked that the late Dr. Jacob Bigelow was accustomed to speak of the tea and coffee as useful adjuncts to other forms of food and drink, but that they are only harmful when taken alone.

In response to certain remarks in regard to the more injurious effect of tea after long infusion, Dr. Bullard read the following quotation from Dr. Roberts' Address on Therapeutics, delivered before the British Medical Association in 1885, as reported in the *British Medical Journal* of August 15th, 1885: "Some persons have supposed that by infusing tea for a very brief period—two or three minutes—the passage of tannin into the beverage could be avoided. This, however, is a delusion. Tannin is one of the most soluble substances known; it melts like sugar in hot water. You can no more have tea without tannin than you can have wine without alcohol, and I found experimentally that tea infused for two minutes had almost exactly the same inbibitory effect on digestion as tea infused for fifteen or twenty minutes."

Dr. Edes observed that one most frequent cause of dyspepsia is the fact that the diet is much deranged. Too much drink and too little food is taken, and the patient gradually becomes anæmic, and the train of symptoms so often noticed in tea-poisoning gradually are developed. In this way tea possesses one curious merit, as the patient can be sustained upon a more attenuated diet than when no tea is taken.

Dr. Farlow remarked that it is marvelous what a proportion of patients seen at the dispensary are totally ignorant of what is a proper condition of the bowels, and the little attention given to regularity of action in evacuation. These patients are almost all tea-topers, and are frequently insufficiently nourished. They generally complain of a feeling of weight in the abdomen, and are also almost invariably nervous.

Dr. Blodgett said that Dr. Cheever expected to have been present at this meeting, but was unavoidably detained. This was the more to be regretted from the fact that Dr. Cheever has had a large and interesting experience in the treatment of cases of disease arising from the inordinate use of tea. The condition of these patients is not always the same, but presents a limited variation in the array of prominent symptoms. One of the most frequently noticed conditions is a highly exalted state of the nervous system with increased reflex excitability, and a tremulous condition of the voluntary muscles, which justifies the name of "tea tremens," from the similarity of this symptom to the tremor belonging to cases of alcoholic poisoning. This is most frequently noticed in servant-girls, who partake frequently and exclusively of tea as a drink and do not obtain sufficient exercise in the air, and live principally on fine white bread, to the exclusion of other more wholesome and necessary articles of natural diet. The result is that the system obtains only an insufficient nutrition, and the organs and functions of the body suffer a loss of organic or functional activity, or both. A very important phenomenon in relation to the detrimental action of tea is its effect upon the teeth and other hard structures of the body. This result is most noticeable in our Irish servant population, and particularly in the children born of parents who themselves emigrated to this country from Ireland. The teeth of the parents are almost universally firm and durable in structure, and beautifully clear and white. The teeth of the children, and especially those of the daughters, however, are found to be poorly formed, to be of brittle structure, and fall an easy prey to caries, and are lost at an early period. This is undoubtedly due to the fact that many of these children are at service as house servants, and when following this occupation are addicted to the tea-tippling and the fine bread above described. The result is, that instead of the full and perfect denture of the parents who lived on plain and coarse food, without any of the abominations of our modern kitchens, these poor creatures obtain only a partial nutrition, the hard structures of the body being deprived of the necessary calcareous supply which resides in the the husk of grain, and is removed in the process of making fine flour, the teeth are insufficiently formed or inadequately maintained and consequently are early lost.

Dr. P. C. Knapp showed a series of

NORMAL ELECTRODES,

in which the size of the disk which is applied to the the surface in connection with the degree of intensity of current is measured by the resistance, constitutes a perfectly adjustable measure of the amount and intensity of the current employed, and is a necessary feature in the practical employment of electricity as a therapeutic agent.

These electrodes are the sizes proposed by Erb[1] in 1882, and now accepted as the standard in regard to size, and with them a new size, recently proposed by Erb,[2] which merits a word of description. In testing the galvanic excitability of nerve or muscle the appearance of contraction depends upon the absolute density of the current employed. This absolute density varies of course directly with the intensity of the current which may be readily measured in milliampères on an absolute galvanometer, and it also varies inversely with the area of the electrode, just as the intensity of a stream of water varies inversely with the size of the tip of the pipe. Hence we have the equation of D equals I divided by Q, where D equals absolute density, I equals intensity, and Q (querschmitt) equals area of electrode. Having a ready measure for I in the milliampère, Erb has suggested the use of a "normal electrode" as a testing electrode, with an area of ten cm., either as a flake 3.2 cm. square, or a round disc, like the one exhibited, with a diameter of 3.5—3.6 cm. We may then say that KaSZ appears at 4 milliampères, normal electrode, or more simply, KaSZ appears at 4-10, or .4 milliampères, the numerator of the fraction denoting the number of milliampères, the denominator the area of the electrode.

[1] Erb Handbuch der Elektrotherapie. Leipzig, 1882.
[2] Neurolog. Centralblatt, January 1, 1886.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, Thursday, April 1, 1886.

THE PRESIDENT, B. F. BAER, M.D., IN THE CHAIR.

W. H. H. GITHENS, SECRETARY.

DR. E. P. BERNARDY read a paper on

THE VALUE OF BINIODIDE OF MERCURY AS AN ANTISEPTIC IN OBSTETRICS.

(See page 422.)

DR. CHAS. HERMON THOMAS had heard the statements of Dr. Bernardy with interest, and surprise that cases of so much gravity could be controlled by such simple means as vaginal injections. His practice and belief has been that such cases require the introduction of washes into the uterus, the washing of the vagina being utterly futile. The doctor related an instance in which a four-para was allowed to die of septicæmia, no effort being made to wash out the uterus, although vaginal antiseptic injections were frequently employed in the case. Six weeks have elapsed since the death of that patient, and in that time the same practitioner has lost three additional parturient patients.

DR. LONGAKER spoke in support of Dr. Bernardy's practice. We have been led to expect a prompt fall of temperature from the use of intra-uterine injections in septicæmia post-partum. His own plan is to discontinue intra-uterine injections after the first thorough washing, unless offensive discharges come from the uterus. He has observed that after the repeated introduction of forceps into the uterus, the introduction of the hand or other means favoring the introduction of air, a peculiar traumatic metritis results, and to relieve this he has been in the habit of introducing into the uterus an iodoform pencil, containing about 1⅔ drachms of iodoform; this prevents future sepsis (see Lusk, last edition). Prompt lowering of the temperature and pulse are the result if this is used, after sepsis has occurred, and even when antiseptic uterine injections have failed. The effect of one of these pencils will last through two or three days, when another may be needed.

DR. HOWARD A. KELLY drew attention to the fact that the biniodide of mercury is almost if not entirely insoluble in water, and that an alcoholic solution would hardly be admissable. He also called attention to the frequent presence of the bichloride as an impurity. He read the following letter from Dr. Francis L. Haynes:

"In reference to the potassio-mercuric-iodide, I may add a little to the facts I mentioned in our conversation. The last case of puerperal septicæmia I have seen in my own practice occurred in Mrs. F., confined December 18, 1885. It was due to the fact that my hands were contaminated with septic matter, and that I trusted entirely to hard scrubbing and to inunction with oil of turpentine to purify them (after Goodell). In this case the pulse was 138, and the temperature ran up to 105°, but she recovered in a few days under copious injections of hot water into the uterus (generally plain, but sometimes with a little carbolic acid added). These injections were given, and during the days on which this treatment was being used I attended several cases of labor, purifying myself with ten per cent. solutions of carbolic acid. These cases had no trouble, but I became ill, as I always do when I use much carbolic acid, and my hands became sore. I now began to use the potassio-mercuric-iodide solution to purify my hands, and since then have had no trouble whatever, although I have attended cases of labor within a few hours after (1) washing out the uterus of a patient of Dr. L's suffering from septicæmia (terminating fatally); (2) after amputating finger and metacarpal bone of a man suffering from gangrene of finger and suppurative cellulitis of the hand and wrist; (3) after digging out putrid placenta after miscarriage (several instances); (4) after performing autopsy in a case of suppurative peritonitis, and bathing my hands freely in the pus. The solution may be used without apparent injury to purify blunt instruments, and it is certainly a great comfort to soak your speculum thoroughly in it after treating a case of gonorrhœa.

How is the solution prepared? A four-ounce bottle is marked with a diamond so as to indicate drachms, and filled with distilled water containing ʒj each of potassium iodide and mercuric iodide. (The cost of this solution is less than ten cents.) It is now a very easy matter to make a solution of any desired strength extemporaneously. A tablespoonful to the pint = one part to 1000 is the strength I generally employ, but after autopsies I use 1 to 500.

How do I prevent my hands from becoming eczematous when using the solution? Once or twice daily, after washing the hands and while they are still damp, about ʒss of glycerine is poured into the palm and thoroughly rubbed into the whole surface of the hands, which are then dried as usual. This is very effectual,

DR. WILLIAM GOODELL has had no experience with biniodide of mercury, but has had with bichloride. He is not sure that Dr. Bernardy is at fault in confining his antiseptic injections principally to the vagina, for where does sepsis usually take place? Not in the uterus, but through wounds of the vagina. In the Charlotte Hospital they have good results from the use of bichloride injections and iodoform. When the Preston Retreat was new they had a good record, but afterwards the per centage of fatal cases became too large. This fault was remedied by the use of bichloride of mercury as a vaginal injection, and the introduction of ʒj of iodoform. The pads to catch the lochial discharges were replaced by absorbent cotton medicated with corrosive sublimate. In the last 140 cases no rise of temperature has occurred during the puerperal period. In these cases the antiseptic applications were all directed to the lower portion of the womb and the vagina. Dr. Bernardy is probably right. A solution of 1 to 2000 is too strong and will produce soreness after operations. He does not like to have the patient on her side during and after the removal of the afterbirth, as it favors the entrance of air into the vagina, as in Sims' position. She should be on her back.

DR. HARRIS inquired if Dr. Bernardy did not use

uterine injections after the removal of the dead fœtus. The effect of a decomposing fœtus with unbroken membranes within the uterus has a remarkably prostrating effect upon both mind and body of mother.

Dr. Githens described a case of post-partum septicæmia in which an offensive leucorrhœa, which had existed before labor and which had been neglected, was the apparent cause. In this case vaginal injections of potassi-mercuric-iodide quickly relieved the undesirable symptoms.

Dr. Thomas thought vaginal injections would be quite sufficient as a prophylactic agent, but would it be considered sufficient if septic peritonitis were present? One thorough uterine wash first and then pencils to prepare for subsequent vaginal washes. In Bellevue Hospital uterine injections are always used when required; washes failed to reduce the temperature.

Dr. Bernardy uses the first injection himself and thoroughly washes out the uterus and continues the injections until the fluid comes away perfectly clear. The firm contraction of the uterus eliminates the liability of absorption there, and the principal abrasions and absorbing surfaces are undoubtedly vaginal. The results at least have been satisfactory.

The pellets exhibited are quite soluble, and are chemically pure; the biniodide has been tested for bichloride, and none is present. The potassium iodide present merely aids in the solubility without affecting the chemical composition of the mercuric iodide.

CHICAGO MEDICAL SOCIETY.

Thirty-fourth Annual Meeting, April 5, 1886.

The President, C. T. Parkes, M.D., in the Chair.

The Treasurer, Harold N. Moyer, M.D., reported a balance of $226.17 in the treasury. Dr. Edmund Andrews, Chairman of the Committee on Library, reported a balance of $210.88, donations of 268 volumes, and purchases of about 1600 volumes during the year.

The following were elected

OFFICERS FOR THE ENSUING YEAR.

President—Dr. Edmund J. Doering.
First Vice-President—Dr. Wm. T. Belfield.
Second Vice-President—Dr. J. F. Todd.
Secretary—Dr. Liston H. Montgomery.
Treasurer—Dr. Harold N. Moyer.
Necrologist—Dr. John Bartlett.

STANDING COMMITTEES.

Committee on Library—Dr. Edmund Andrews (whose term had expired).

Committee on Judiciary—Dr. Addison H. Foster, Dr. Wm. E. Quine, Dr. Truman W. Miller.

Committee on Membership—Dr. Gerhard C. Paoli, Dr. D. A. K. Steele, Dr. E. F. Ingals.

Committee on Publication—Dr. John A. Robison, Dr. E. W. Andrews, Dr. R. Tilley.

The Society then elected the following

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION.

Wm. T. Belfield,	I. N. Danforth,
Franklin H. Martin,	H. M. Starkey,
D. R. Brower,	A. R. Reynolds,
D. W. Graham,	F. E. Waxham,
D. A. K. Steele,	F. C. Schaefer,
Edwin Powell,	R. H. Babcock,
J. H. Plecker,	Augustus V. Park,
W. W. Allport,	E. A. Baldwin,
N. S. Davis, Sr.,	Charles W. Purdy,
W. W. Jaggard,	L. T. Potter,
H. M. Thomas,	Robert Tilley,
Liston H. Montgomery,	James Burry,
O. T. Schenick	S. C. DeVeny,
N. S. Davis, Jr.,	W. E. Casselberry,
G. C. Paoli,	T. W. Miller,
Charles T. Parkes,	F. A. Stanley.
E. M. McAuliffe,	

Those wishing to attend the next meeting of the Illinois State Medical Society may apply to the Secretary for delegates' certificates.

FOREIGN CORRESPONDENCE.

LETTER FROM PARIS.

(FROM OUR OWN CORRESPONDENT.)

The Summer Session of the Faculté de Médecine—The Lecturers—Intra-parenchymatous Injections of Bichloride of Mercury in Tuberculosis—Congenital Fibrous Band of the Leg—The French Surgical Congress—Madame Ribard and Paul Bert.

The summer session of the Paris Faculty of Medicine began on March 15th. The following is a complete list of the lecturers and subjects for the session, in order that your readers may become acquainted with the names of the leading medical men of this city: Professors Baillon, Medical Natural History; Béclard, Physiology; Guyon, Surgical Pathology; Brouardel, Medical Jurisprudence; Regnauld, Pharmacology; Bouchard, Pathology and General Therapeutics; Damaschino, Medical Pathology; Vulpian, Experimental and Comparative Pathology; Tarnier, Obstetrics; Proust, Hygiene; Hayem, Materia Medica and Therapeutics. In addition to his theoretical lectures, Professor Brouardel delivers practical instruction at the Morgue on Forensic Medicine and Toxicology.

Clinics.—Professors Germain Sée, Medicine, at l'Hôtel Dieu; Hardy, Medicine, at La Charité; Potain, Medicine, at the Necker Hospital; Jaccoud, Medicine, at La Pitié; Richet, Surgery, at Hôtel Dieu; Verneuil, Surgery, at La Pitié; Trélat, Surgery, at La Charité; Le Fort, Surgery, at Necker Hospital.

Specialties.—Professors Ball, Mental Pathology and Diseases of the Encephalon, at the St. Anne Asylum; Grancher, Diseases of Children; Fournier, Syphilitic and Cutaneous Affections, at the St. Louis Hospital; Charcot, Diseases of the Nervous System, at the Salpétrière; Panas, Ophthalmology, at the Hôtel Dieu; Pajot, Clinical Obstetrics.

Supplementary Lectures.—These are delivered by Agrégés, who thus prepare themselves for the higher function of Professor. The following are the names of those engaged for the session:

Drs. Joffroy, Medical Pathology; Humbert, Surgical Pathology; Hanriot, Medical Chemistry; Blanchard, Natural History; Gariel, Physics; Regnier, Physiology; Hanot, Morbid Anatomy; Pinard, Obstetrics.

In addition to the above, practical instruction is given on the following subjects by

Drs. Hanriot, Chemistry; Guébhard, Physics; Faguet, Natural History; Laborde, Physiology; Rémy, Histology; Farabeuf, Operative Surgery; Gombault, Morbid Anatomy.

Thus it may be seen that the French medical students have great advantages over those of other countries, particularly as the above lectures are given gratuitously, and are open to all nations.

The natural outcome of the parasitic doctrine of diseases is of course the tendency to cure them by remedies reputed to be anti-parasitic, and these are generally applied either by the mouth or by external applications. But Dr. Gougenheim thinks that unless the parasites can be directly attacked these remedies can be of little or no avail. He has therefore conceived the idea of treating pulmonary tuberculosis by intra-parenchymatous injections of the bichloride of mercury, and he lately read a paper on the subject before the Société Médicale des Hôpitaux de Paris. The author performed the injections with a Pravaz's syringe, which he introduces on the left side below the clavicle, through the first intercostal space, and on the right side through the first two intercostal spaces. In order to avoid all accidents it is necessary to make the injection at a distance from the sternum and the neighboring rib, in order not to injure the intercostal and mammary vessels and nerves; neither should it be made too near the clavicle, or the subclavian vein may be injured; the subcutaneous veins should be avoided. The injection should be given slowly, and the liquid employed is a solution of the bichloride of mercury in the proportion of 1 in 2000, 1 in 1000, and 1 in 100, the fluid being previously heated to 37° (98.6° F.).

This treatment was adopted with thirty-three patients, most of whom were in an advanced stage of phthisis. In twenty-one instances improvement was quick and undeniable, as ascertained by auscultation. Ten patients died; of these, seven presented local modifications of lesions, which were easily detected at the necropsies. At the necropsies of patients who had been thus treated, Dr. Gougenheim never observed any muscular, pleural, or pulmonary lesions, which could be attributed to these injections. One patient had hæmoptysis, and the injections were discontinued; another left the hospital whilst under this treatment.

Dr. Reclus, at a recent meeting of the Paris Surgical Society, presented a female patient who was the subject of a rare lesion. One of her legs was constricted by a congenital fibrous band. Last year Dr. Reclus removed two-thirds of the band, and subsequently the remaining third. The success resulting has been perfect. It has been suggested that this case evidently belongs to the same class as those in which amputation is produced *in utero* by constricting bands.

The French Surgical Congress will hold its second meeting at Paris from October 18 to October 21. The subjects contained in the programme are: Nature, Pathogenesis and Treatment of Tetanus; Nephrotomy and Nephrectomy; Orthopædic Resections; Surgical Operations in Irreducible Dislocations. Papers on other subjects cannot be read at the Congress unless the conclusions of the author are forwarded to the Secretary, Dr. S. Pozzi, 10 Place Vendome, Paris, between July 1 and July 13, 1886. Papers that are not read will not be printed in the transactions.

Madame Ribard, M.D., of Paris, having been appointed physician to the family of M. Paul Bert, the newly-appointed Governor-General of Tonquin, has left Paris for that Colony. Madame Ribard is also entrusted with the organization of an Ophthalmic Hospital, as well as a vaccine establishment, in that country.

A. B.

DOMESTIC CORRESPONDENCE

LETTER FROM NEW YORK.

(FROM OUR OWN CORRESPONDENT.)

Is Disease of the Uterine Appendages as Frequent as has been represented—The Academy of Medicine; Changes in the Constitution.

At the meeting of the Academy of Medicine held April 1, Dr. Henry C. Coe, Pathologist to the Woman's Hospital, read a very timely paper, entitled, *Is Disease of the Uterine Appendages as Frequent as it has been Represented?* which it is hoped will have some effect, at least, in putting a check upon the altogether reckless resort to Tait's operation which has of late been of such frequent occurrence in this country. Having remarked that there was much yet to be learned in regard to the pathology of these organs, he said very truly that agnosticism in regard to ovarian and tubal disease met with very little encouragement at the present day, and that this was due to a large extent to the surgeon.

In considering the condition and appearance of the ovary in any given case, he said, it must not be forgotten that during the entire sexual life of the female constant changes are going on in these organs. Hence it was often very difficult to say just where the normal ends and the pathological begins. Nothing was at present more common than to remove ovaries because they were "cystic," on the ground that because of this condition they were functionally useless. Yet he had seen cysts as large as a marble which could not be called pathological, since they contained perfectly healthy ova which were certainly capable of being impregnated. Taking up the pathological conditions of the ovary as viewed by the laparotomist, Dr. Coe said that many of the variations of the organ in size and shape which were commonly regarded as pathological by him were found in

ovaries which were to be looked upon as in fact entirely normal, at least as far as function was concerned. Congestion and moderate enlargement did not necessarily imply chronic ovaritis and indicate oöphorectomy; since, when the other pelvic organs were for any reason in a state of hyperæmia, the ovaries were naturally found hyperæmic also.

In the same way, a decided diminution in size might not be pathological, but merely an indication of senile atrophy. Again, certain conditions which are regarded by the laparotomist as pathological, such as thickening of the external covering of the organ, might not be so in reality; since such thickening was not at all abnormal in senile atrophy, or after very frequent ovulation, when localized thickening is very common, even when senile atrophy does not exist. But, although there might be exterior thickening, it was no indication that there was cirrhosis of the internal stroma of the organ which interfered with its functions.

Passing on to consider the subject from a microscopical point of view, he said that in order that the pathologist might give an intelligent opinion concerning any removed ovary presented to him for examination, he must be familiar with the normal histology of the organ, and, on account of the constant changes going on in the ovaries, previously referred to, this was a matter which involved no little difficulty. The pathological appearances of well-marked disease were readily recognizable; but the lesser ones were undoubtedly very hard to differentiate. Again, because one portion of the organ was affected, it was no reason why the whole ovary should be implicated in the pathological process; and, acting on this principle, Schröder had lately been operating in such a way as to remove the diseased portions, and allow the rest to remain. The number of cases thus far recorded, however, was too small to base any positive conclusions upon as to the practical utility of this method; but it was, at all events, a step in the right direction.

In speaking of tubal disease he said that there could be no doubt that Tait's operation had of late been greatly abused. No reasonable objection could be urged against the removal of Fallopian tubes which were filled with pus; but this was not the case with a large number of the tubes which are taken out. Tait said that in chronic disease of the ovaries the tubes were always affected; but Dr. Coe denied this, as the result of his personal pathological investigations. Some of the so-called diseases of the tubes were not recognizable by the pathologist at all. There was no doubt about pyo-salpinx or hydro-salpinx, when these conditions were present; but as to so-called "catarrhal salpingitis," commencing pyo-salpinx, and other presumed pathological conditions which constantly pass unchallenged in learned societies, there was very good reason for doubt. In cases where the diagnosis of catarrhal salpingitis had been made, and the tubes and ovaries removed in consequence of the condition, Dr. Coe had found on subsequent examination simply moderate hyperæmia, with a thin coating of mucus, which might exist in a perfectly normal Fallopian tube; there being no evidence whatever of any inflammation. As long as the lumen was free, and the lining mucous membrane capable of performing its function, the tube was not abnormal, notwithstanding the fact that there might be slight adhesions of the fimbriated extremity.

From his examinations he could say that pyo-salpinx exists in about one-fifth of the cases where Tait's operation is performed. Hydro-salpinx is considerably less common, and hæmo-salpinx extremely rare. If there was no pus discernible, there was certainly no pyo-salpinx, just as there could be no abscess anywhere without pus. The pain that was so often attributed to disease of the tubes Dr. Coe believed to be generally due to localized peritonitis, and sometimes to neuralgia pure and simple. The one criticism that he had to make on American laparotomists, he said, was that they do not follow up their cases for a sufficiently long time. As a rule, they were reported very shortly after the operation, when the results often seem all that could be desired; but if the histories could be given at the end of from six months to two years, it would not infrequently be found that no permanent benefit whatever had resulted from the procedure. He had met with many women under these circumstances who still suffered in the same way as before the operation.

The deductions drawn by Dr. Coe were somewhat as follows:

1. Ovarian disease is not as common as is now generally supposed. This impression is derived from the surgeon, and not from the pathologist.

2. Because the ovary is partially diseased, it does not follow that the whole organ is involved in the pathological process.

3. "Cystic" and "cystic degeneration" are mischievous terms, which have been productive of much evil by leading to false conclusions and unnecessary ovariotomies in consequence.

4. Actual disease of the tubes is far less frequent than many surgeons would have us believe.

5. Localized peritonitis will account for much of the trouble attributed to disease of the uterine appendages.

While some of the gynecologists who took part in the discussion of the paper were disposed to take issue with its author in regard to the frequency of disease of the uterine appendages, it was noticeable that without an exception they all condemned the frequent removal of these organs. Even Dr. W. Gill Wylie, whose name is more closely identified with Tait's operation than almost any other New York laparotomist, was careful to put himself on record on the conservative side by stating that at the present time he seldom or never resorted to this procedure except in the case of pyo-salpinx.

Dr. Lusk, whose views were more entirely in accord with those of the essayist of the evening than any of the other speakers, remarked that in his paper Dr. Coe had covered nearly all the ground which he had himself been accustomed to take in the tirades against the abuse of Tait's operation with which many of his gynecological friends were now familiar. He was by no means an enemy of the operation, he said; but thought it did great good in its place. More

than once, however, he had stood by and seen tubes removed which were described by various pathological designations, but which seemed to him to be entirely normal. In the same way, he had seen ovaries taken out, of which it was said that they were in a state of commencing cystic degeneration, but which appeared to him typical examples of physiological ovaries, precisely like those he had formerly been accustomed to exhibit to his classes as such when he used to teach that branch of physiology. He then took great interest, he said, in pointing out the changes which are constantly going on in these organs; and these so-called cystic ovaries, which had been removed for imaginary disease, were simply ovaries which were undergoing these same physiological changes. Since surgeons had come to be able to remove the ovaries and tubes with comparatively little risk to the patient, the operation was performed entirely too frequently. Tait's advice was to cut open the abdomen and examine the condition of the uterine appendages; when, if they were found all right, they were to be returned to their places in the pelvic cavity. But he himself had yet to meet with the surgeon who. after getting thus far in the operation, did not take out the organs altogether, whatever their condition might be.

Dr. Lusk believed that there were very few cases in which the condition of pyo-salpinx could not be diagnosticated by proper manipulation with the fingers of one hand in the vagina, and that the great mistake of the present day among gynecologists was the too frequent opening of the abdomen. Unless the enlarged tube could be felt, in the manner described, outside the body, the operation ought not to be performed, and he said that if this rule were generally observed, there would not be so many tubes removed. In the course of time he thought it probable that even in this class of cases Tait's operation might be avoided by the use of some such instrument as that devised by Dr. Mundé, which consists of a syringe with a hypodermic needle attached.

In regard to this last point of Dr. Lusk Dr. Wylie said that he did not think that aspiration would cure any case of pyo-salpinx, because the pus would be sure to return after it had been evacuated. Another objection to it was that there was a possibility of causing fatal injury with the instrument, by wounding the uterus. In the course of his remarks Dr. Wylie expressed his conviction that in the great majority of cases localized peritonitis was associated with disease of the ovaries and tubes; an opinion which was also coincided with by Drs. Polk, Mundé and Noegerrath.

In closing the discussion Dr. Coe stated that his anatomical studies had led him to look with some doubt upon a diagnosis resting on clinical observation alone. Fearing that the position which these investigations had obliged him to take in regard to the comparative infrequency of disease of the uterine appendages might perhaps be thought not altogether well supported, he had written to obtain the opinion of Dr. Wm. H. Welch, now of the Johns Hopkins University, of Baltimore, who was acknowledged to be one of the most distinguished microscopists in the country, and who had had a very large experience in this special field. Dr. Welch had replied that he believed Dr. Coe's position to be well taken. He said that he saw very few cases of pyo-salpinx in his examinations, and that he was continually receiving ovaries and tubes, removed by laparotomy, which were, as far as he could make out, entirely free from disease. He furthermore expressed the opinion that it was a mistake to suppose that the so-called "cystic" ovaries would degenerate into cystoma.

It is probably not known at all out of New York, and perhaps to a very limited extent among the profession even here, what radical changes have been made during the past winter in the constitution and by-laws of the Academy of Medicine. These changes, however, constitute them, in many essential features, an entirely different instrument from the old constistitution and by-laws. In comparing the old and the new constitution, the first change that strikes one is in regard to the objects of the Academy. In the old, these are stated to be: (1) The cultivation of the science of medicine. (2) The advancement of the character and honor of the profession. (3) The elevation of the standard of medical education. (4) The promotion of the public health. In the new, the single object is announced to be "the promotion of the science and art of medicine." While many of the changes are decided improvements, as regards the details of the work of the Academy and the simplicity and accuracy of the wording of the various sections, the most striking and extraordinary one is in regard to the matter of ethics. In the new constitution and by-laws there is absolutely no reference in any manner whatever to this subject. In the old by-laws, Section 5 of No. XIV reads as follows: "All questions of ethics in other respects shall, as far as applicable, be adjudged in accordance with the Code of Ethics promulgated by the American Medical Association and adopted by the Academy." In the new instrument not only is the New Code not substituted for the National one, but it out-Herods Herod by cutting completely loose from all codes.

Practically the only reference to the matter of discipline now found is in the eighth article of the constitution, in which it is provided that the Academy may, by a three-fourths vote of the resident Fellows (the printed call for the meeting having contained a notice of the motion to suspend or expel), suspend or expel a Fellow "for violation of its regulations." The only other reference to discipline in the constitution is in Article VII, where it is stated that the certificate of fellowship may be revoked for cause; but as there is no provision whatever for the manner in which this revocation is to be accomplished, it really amounts to nothing. The only reference of the kind in the by-laws is in the eleventh section of No. X, which reads as follows: "It (the Council) shall, on a written statement signed by a complainant, and duly forwarded through the Recording Secretary, take cognizance of any complaint against a Fellow. The Council may, after investigation, dismiss a complaint or transmit its finding thereon to the Academy for further action." From this it will be seen that the matter of disciplining is therefore wholly comprised in Article VIII of the constitution, which, as just mentioned, prescribes that he may be

suspended or expelled for violation of the Academy's regulations. As there is nothing whatever in these "regulations" of the faintest ethical import, it is evident that a Fellow can be suspended or expelled solely for a breach of certain routine rules. He may be a debauchee, or sot, a blackleg or a thief; but so long as he acts in accordance with these "regulations," the Academy cannot touch him; and if it attempted to do so, the defense that he had not violated the regulations would hold good in any court of law. There is not even the saving clause of "conduct unbecoming a gentleman" anywhere to be found.

Furthermore, it is not necessary, so far as any statutory provisions are concerned, that in order to belong to the Academy a person should be a *regular* graduate in medicine. So far as regards any restriction in the constitution or by-laws, a homœopath, eclectic, "physio-medical," "herb doctor," or any kind of a charlatan whatever, is entitled to become a Fellow if only he is the possessor of a diploma or license, and has resided in New York or its vicinity for three years. There is absolutely nothing said about what sort of a college or other body the candidate must have derived his diploma or license from; it is simply required that he "must have been a graduate or licentiate in medicine." It is noticeable that the committee on education, as well as that on ethics, has been entirely abolished.

Hitherto the Academy of Medicine, although many of its Fellows individually repudiated the National Code, has been entitled, as a body, to representation in the American Medical Association by reason of its technical adherence to the Code; but, of course, now that it has repudiated the latter in its corporate capacity, it has placed itself in the same anomalous position as the Medical Society of the State of New York. P. B. P.

LAPAROTOMY FOR PELVIC ABSCESS.

To the Editor of the Journal:

Dear Sir:—I entirely agree with Dr. Christian Fenger in his remarks on Dr. Jackson's paper, in a recent meeting of the Chicago Gynecological Society, when he says: "The operation performed in Dr. Jackson's case I should not call a laparotomy at all, but simply an oncotomy. An abscess was opened, and the operation does not differ materially from the opening of a deep-seated abscess in any other region of the body, *e. g.*, in an extremity."

In the cases reported done in this country there was one performed by me in June, 1884. I think it was the first successful case of laparotomy for pelvic abscess done in this country. It will be found in the *Medical News*, for 1884. In this case the sac of the abscess was stitched to the abdominal wound, and then opened and drained. The woman is still living and in excellent health. I think this case was reported by Dr. Stone, my assistant, and is probably referred to in Dr. Fenger's list, given in his remarks.

Very respectfully, R. S. Sutton, M.D.

419 Penn Ave., Pittsburgh.

STATE MEDICINE.

REGULATION OF MEDICAL PRACTICE IN IOWA.

The following Bill for an act to regulate the practice of medicine and surgery in the State of Iowa has been recently passed:

Be it enacted by the General Assembly of the State of Iowa:

Section 1. That every person practicing medicine, surgery or obstetrics, in any of their departments, within this State, shall possess the qualifications required by this act. If a graduate in medicine such person shall present his or her diploma to the State Board of Examiners, for verification as to its genuineness. If the diploma is found genuine and is issued by a medical school legally organized and in good standing, of which the State Board of examiners shall determine, and if the person presenting and claiming such diploma be the person to whom the same was originally granted, then the State Board of Examiners shall issue its certificate to that effect signed by not less than five physicians thereof, representing one or more physicians of the schools on the board, and such certificate shall be conclusive as to the right of the lawful holder to practise medicine, surgery and obstetrics within this State. If not a graduate the person practising medicine or surgery within this State, unless he or she shall have been in continuous practice in this State for a period of not less than five years, of which he or she shall present to the State Board of Examiners satisfactory evidence in the form of affidavits, shall appear before said State Board of Examiners and submit to such examination as said board may require. All examinations shall be conducted in writing, and all examination papers, together with the reports and action of the examiners thereon, shall be preserved as the records of the board for a period of five years, during which time they shall remain open for inspection at the office of the said State Board of Examiners. Such examinations shall be in anatomy, physiology, general chemistry, pathology, therapeutics, principles and practice of medicine, surgery and obstetrics. *Provided*, that each applicant upon receiving from the secretary of the board an order for an examination shall receive also a confidential number which he or she shall place upon his or her examination papers so that when said papers are passed upon by the examiners, the latter shall not know by what applicant said papers have been prepared. That upon each day of examination all candidates be given the same set or sets of questions. It is further provided that the examination papers shall be marked upon the scale of one hundred (100) and that in order to secure a license, it shall be necessary for the applicant to attain such average as shall hereafter be determined by the State Board of Examiners. And if such examination be satisfactory to at least five physicians of said board, representing the different schools of medicine on the board, the board shall issue a certificate which shall entitle the lawful holder thereof to all the rights and privileges herein provided, and the physicians and the secretary

of the State Board of health shall constitute and be deemed a Board of Examiners for the purpose of this act.

SEC. 2. The State Board of Examiners shall procure a seal within sixty days after the passage of this act, and through the secretary of said board shall receive applications for certificates and examinations. The president, or any member of the board, shall have the authority to administer oaths and take testimony in all matters relating to their duties as examiners aforesaid. The board shall provide three forms of certificates: One for persons in possession of genuine diplomas, one for candidates examined by the board, and one for persons who have practised medicine or surgery in any of its departments for five years as provided in this act. Said certificates shall be signed by not less than five physicians of the board, and this number may act as examining board in the absence of the full board, provided that one or more members of the different schools of medicine represented in the State Board of Health shall also be represented in the Board of Examiners. The Board of Examiners shall hold meetings at such places as will best accommodate applicants residing in different portions of the State, and at such times as they shall deem best and due notice of the time and place of such meetings shall be published.

SEC. 3. The board shall examine all diplomas submitted to them for such purpose to determine their genuineness and the rightful ownership of the person presenting the same. The affidavit of the applicant and holder of any diploma that he or she is the person therein named, and is the lawful possessor thereof, shall be necessary to verify the same with such other testimony as the board may require. Diplomas and accompanying affidavits may be presented in person or by proxy. If the diploma shall be found genuine, and in possession of the person to whom it was issued, the State Board of Examiners shall, upon the payment of a fee of two dollars, to the secretary of the board, issue a certificate to the holder of such diploma, and no further fee or sum shall be demanded or collected from said applicant by said board for such certificate. If the diploma shall be found to be fraudulent, or not lawfully in the possession of the holder or owner thereof, the person presenting such diploma or holding or claiming possession thereof, shall be deemed guilty of a misdemeanor, and on conviction thereof, before any court of competent jurisdiction, be fined not less than twenty dollars nor more than one hundred dollars.

SEC. 4. Every person holding a certificate issued by the State Board of Examiners, shall, within sixty days after the date of such certificate, have the same recorded in the office of the county recorder in the county wherein he resides, and should he remove from one county to another to practise medicine, surgery or obstetrics, his certificate must be recorded in the county to which he removes. The county recorder shall indorse upon the certificate the date of record, and he shall be entitled to charge and receive a fee of fifty cents for his services, to be paid by the applicant.

SEC. 5. The county recorder shall record in a book provided for that purpose, a complete list of the certificates presented for record, and the date of their issue by the State Board of Examiners. If the certificate is issued by reason of a diploma, the name of the medical college conferring the same, and the date when conferred shall be recorded; and when such certificate shall have been granted upon the examination of the board, or because of seven years' practice in the State, such facts shall be recorded. Said record shall be open for inspection during business hours.

SEC. 6. Candidates for examination shall pay in advance to the Secretary of the State Board of Examiners, a fee of ten dollars, which fee, together with the fees received for certificates, shall defray the entire expense of the aforesaid Board of Examiners, and the balance shall be turned over to the State Treasurer for the benefit of the school fund, except such an amount as will pay each member of the Board ten dollars ($10) per day during the time he is in actual attendance upon the session of the said Board for the purpose of performing the duties required of him under this act, and as will pay the Secretary of Board such a salary as they may allow, not to exceed five dollars per day during the time he is actually engaged in performing the work of the Board under this act, and each member of the Board of Examiners shall also receive a sufficient amount to defray his actual and necessary expenses while in the discharge of the duties herein provided. Any one failing to pass the required examination, shall be entitled to a second examination within twelve months without fee. Provided that any applicant for examination by notice in writing to the Secretary shall be entitled to an examination within three months from the time of said notice, and a failure to give such opportunity, shall entitle such applicant to practice without the certificate required by this act, until the next regular meeting of said Board.

SEC. 7. The State Board of Examiners may refuse to grant a certificate to any person who has been convicted of a felony committed in the practice of his profession, or in connection therewith, may revoke certificates for like cause, or for palpable evidence of imcompetency, and such refusal or revocation shall prohibit such person from practicing medicine, surgery and obstetrics, *provided*, such refusal or revocation of a certificate can only be made with the affirmative vote of at least five physicians of the State Board of Examiners, in which number shall be included one or more members of the different schools of medicine represented in said Board; and *provided, further*, that the standing of a legally chartered medical college from which such a diploma may be presented, shall not be questioned except by a like vote.

SEC. 8. Any person shall be deemed as practising medicine, surgery or obstetrics, or to be a physician within the meaning of this act, who shall publicly profess to be a physician, surgeon or obstetrician and assume the duties, or who shall make a practice of prescribing or of prescribing and furnishing medicine for the sick, or who shall publicly profess to cure or heal, by any means whatsoever, but nothing in this

act shall be construed to prohibit students of medicine, surgery or obstetrics from prescribing under the supervision of preceptors, or gratuitous service in case of emergency, nor shall this act extend to prohibit women who are now engaged in the practice of midwifery, nor to prevent the advertising, selling or prescribing natural mineral waters flowing from wells or springs, nor shall this act apply to surgeons of the United States army and navy, and marine hospital service, nor to physicians as herein defined who have been in continuous practice in this State for seven years, three years of which time shall have been in one locality; *provided*, such physician shall furnish the State Board of Examiners satisfactory evidence of such continuous practice, and shall procure the proper certificate as provided in this act, and for which certificate such physician shall pay to the Secretary of the State Board of Examiners a fee of two dollars, and the Board of Examiners shall grant a certificate to such applicant; nor shall this apply to registered pharmacists when filling prescriptions, nor shall it be construed to interfere with the sale of patent or proprietary medicines in the regular course of trade.

SEC. 9. Any person who shall practise medicine or surgery within this State, without having complied with the provisions of this act, and who is not embraced in any of the exceptions, or after being prohibited from so doing, as provided in section 7 of this act, shall be deemed guilty of a misdemeanor, and shall, on conviction thereof, be punished by a fine of not less than fifty nor more than one hundred dollars, or by imprisonment in the county jail not less than ten days nor more than thirty days.

SEC. 10. Any person who shall file, or attempt to file, with the State Board of Examiners, as his or her own, the diploma of another person, or who shall file or attempt to file with the county recorder the certificate of another person as his or her own, or who shall file or attempt to file a diploma or certificate with the true name erased therefrom and the claimant's name inserted, or who shall file or attempt to file any forged affidavit of identification, shall be deemed guilty of the crime of forgery.

SEC. 11. The penalties, as provided in this act, for violations thereof, shall not be enforced prior to the first day of January, A. D. 1887.

SEC. 12. All acts or parts of acts in conflict with this act, are hereby repealed.

ASSOCIATION ITEMS.

AMERICAN MEDICAL ASSOCIATION.

The Thirty-seventh Annual Session will be held in St. Louis, Mo., on Tuesday, Wednesday, Thursday and Friday, May 4, 5, 6 and 7, commencing on Tuesday at 11 A.M.

The delegates shall receive their appointment from permanently organized State Medical Societies and such County and District Medical Societies *as are recognized by representation in their respective State Societies*, and from the Medical Department of the Army and Navy, and the Marine Hospital Service of the United States.

Each State, County, and District Medical Society entitled to representation shall have the privilege of sending to the Association one delegate for every ten of its regular resident members, and one for every additional fraction of more than half that number: *Provided*, however, that the number of delegates for any particular State, territory, county, city or town shall not exceed the ratio of one in ten of the resident physicians who may have signed the Code of Ethics of the Association.

Secretaries of Medical Societies, as above designated, are earnestly requested to forward, *at once*, lists of their delegates.

Also, that the Permanent Secretary may be enabled to erase from the roll the names of those who have forfeited their membership, the Secretaries *are, by special resolution*, requested to send to him, annually, a corrected list of the membership of their respective Societies.

SECTIONS.

"The Chairman of the several Sections shall prepare and read, in the general sessions of the Association, papers on the advances and discoveries of the past year in the branches of science included in their respective Sections. . ."—*By-Laws*, Art. 11, Sec. 4.

Practice of Medicine, Materia, Medica and Physiology.—Dr. J. T. Whittaker, Cincinnati, Ohio, *Chairman*; Dr. B. L. Coleman, Lexington, Ky., *Secretary*.

Obstetrics and Diseases of Women and Children.—Dr. S. C. Gordon, Portland, Me., *Chairman*; Dr. J. F. Y. Paine, Galveston, Texas. *Secretary*.

Surgery and Anatomy.—Dr. Nicholas Senn, Milwaukee, Wis., *Chairman;* Dr. H. H. Mudd, St. Louis, Mo., *Secretary*.

State Medicine.—Dr. John H. Rauch, Springfield, Ill., *Chairman*; Dr. F. E. Daniel, Austin, Texas, *Sec'y*.

Ophthalmology, Otology, Laryngology.—Dr. Eugene Smith, Detroit, Mich., *Chairman*; Dr. J. F. Fulton, St. Paul, Minn., *Secretary*.

Diseases of Children.—Dr. W. D. Haggard, Nashville, Tenn., *Chairman*; Dr. W. B. Lawrence, Batesville, Ark., *Secretary*.

Oral and Dental Surgery.—Dr. John S. Marshall, Chicago, Ill., *Chairman*; Dr. A. E. Baldwin, Chicago, Ill., *Secretary*.

A member desiring to read a paper before a Section should forward the paper, or its *title* and *length* (not to exceed twenty minutes in reading), to the Chairman of the Committee of Arrangements, at least one month before the meeting.—*By-Laws*.

Committee of Arrangements.—Dr. Le Grand Atwood, St. Louis, Missouri, *Chairman*.

AMENDMENTS TO BY-LAWS.

By Dr. Foster Pratt, Mich.—Each Section shall nominate its Chairman and Secretary—all other nominations to be made, as now, by the nominating Committee.

By Dr. I. N. Quimby, N. J.—Create a new Section, to be known as the Section on Medical Jurisprudence.

WM. B. ATKINSON, M.D.,
Permanent Secretary.
1400 Pine St., S. W. cor. Broad, Philadelphia.

ROUND TRIP TICKETS at reduced rates will be issued to delegates attending the next meeting of the American Medical Association, on the 4th of May next, at St. Louis, Mo., by the following agents of the Chesapeake & Ohio Railroad: H. W. Fuller, Gen'l Pass. Agent, Richmond, Va.; Frank Trigg, Pass. Agent, 513 Pennsylvania Ave., Washington, D. C.: S. R. Seal, Ticket Agent, 339 Broadway, N. Y. The trip on the ocean from New York via the Old Dominion line of steamers to Old Point Comfort, or Richmond, Va., is perfectly delightful at this season of the year, and from those points and Washington City over the C. & O., through the mountains of Virginia via the celebrated White Sulphur Springs, West Virginia and Louisville to St. Louis, Mo., the scenery is grand and beautiful beyond description. Delegates from all points on the Missouri Railroad, including Kansas City and St. Joseph, Mo., Leavenworth and Atchison, Kan., and Omaha, Neb., will have until May 30 before returning.

Other weekly medical journals will please copy.

R. M. JORDAN, M.D.,
Chairman Transportation Committee.

St Louis, Mo.

RAILWAY FACILITIES TO THE ASSOCIATION MEETING.—The regular through trains of the Illinois Central Railroad from Chicago to St. Louis will afford excellent accommodations for delegates who wish to attend the meeting of the American Medical Association at St. Louis the first week in May. The night express, with Pullman sleeping cars, leaves Chicago at 8:30 P.M., and arrives in St. Louis at 7 A.M. The rates are $7.50 round-trip.

The rates on the Baltimore and Ohio Railway for those coming from the East and South-east are full fare coming and one-third fare returning.

The Illinois Central, Chicago and Alton, and the Wabash Railways have agreed to fix the rates from Chicago to the meeting of the Association, for members, at $7.50 *round-trip*.

The rate by the Pennsylvania Railroad, from Philadelphia to St. Louis and return, will be $30.35. By the Baltimore and Ohio, in consequence of their low Western rates, it will be $23.75, with the privilege of stop-over at Washington or Baltimore if desired.

MISCELLANEOUS.

NOTICE OF REMOVAL.— Dr. T. Gaillard Thomas has removed from 294 5th avenue, New York, to 600 Madison avenue, between 57th and 58th streets.

THE LOCAL COMMITTEE OF ARRANGEMENTS AND THE DEATH OF DR. FLINT.—*Whereas*, The members of the Local Committee of Arrangements have heard with sorrow of the sudden death of Professor Austin Flint, M.D., LL.D., whose eminent services to medical science, and whose life-work in practical medicine, had endeared him to the medical profession, and whose private and personal character was such as to insure him the admiration and respect of the profession in this country and abroad; therefore, be it

Resolved, That this Committee thus publicly express their deep regret at his death, and tender to the family of the deceased their most profound sympathy.

J. B, HAMILTON, M.D.,
A. Y. P. GARNETT, M.D.,
D. R. HAGNER, M.D.,
} *Committee.*

Washington, April 5, 1886.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM MARCH 27, 1886, TO APRIL 9, 1886.

Major Henry McElderry, Surgeon, relieved from further duty in connection with the New Orleans Exposition, and ordered, on the expiration of his present leave of absence, for duty in Dept. East. (S. O. 71, A. G. O., March 26, 1886.)

Asst. Surgeon Leonard Y. Loring, granted leave of absence for one month, provided that during his absence he furnishes the necessary medical attendance at San Diego Bks., Cal. (S. O. 19, Dept. Cal., March 24, 1886.)

Asst. Surgeon Jno. Van S. Hoff, granted one month's leave of absence. (S. O. 29, Dept. Mo., March 29, 1886.)

Asst. Surgeon J. M. Banister, granted leave of absence for one month, to commence on or about April 2, 1886. (S. O. 63, Dept. East, March 26, 1886.

Asst. Surgeon Aaron H. Appel, granted leave of absence for one month. (S. O. 66, Dept. East, March 30, 1886.)

Major Albert Hartsuff, Surgeon, granted leave of absence for fifteen days. (S. O. 71, Dept. East, April 7, 1886.)

Major Henry McElderry, Surgeon U. S. Army, ordered for duty as Post Surgeon, Ft. Wayne, Mich. (S. O. 69, Dept. East, April 2, 1886.)

Capt. James C. Merrill, Asst. Surgeon, granted leave of absence for three months. (S. O. 81, A. G. O., April 7, 1886.)

Capt. Victor Biart, Asst. Surgeon, sick leave of absence still further extended one year on account of sickness. (S. O. 79, A. G. O., April 5, 1886.)

Asst. Surgeon Richard W. Johnson, relieved from duty at Ft. Buford, D. T., and ordered for temporary duty at Ft. Snelling, Minn. (S. O. 28, Dept, Dak., March 29, 1886.)

Asst. Surgeon R. L. Robertson, on expiration of his present leave of absence, will be relieved from duty in Dept. Texas, and will report in person to commanding general Dept. Dak. for assignment to duty. (S. O. 78, Dept. Dak., April 3, 1886.)

Capt. Jno. V. Lauderdale, Asst. Surgeon, from Dept Dakota to Dept. Texas.

Capt. Geo. W. Adair, Asst. Surgeon, from Dept. Dakota to Dept. East.

Capt. Jas. A. Finley, Asst. Surgeon, from Dept. Texas to Dept. Dakota.

Capt. H. S. Kilbourne, Asst. Surgeon, from Dept. Dakota to Dept. Columbia.

Capt. E. F. Gardner, Asst. Surgeon, from Dept. Columbia to Dept. East.

Capt. Wm. W. Gray, Asst. Surgeon, from Dept. East to Dept. Dakota.

Capt. J. M. Banister, Asst. Surgeon, from Dept. East (upon the expiration of his present leave of absence) to Dept. Columbia.

First Lieut. E. C. Carter, Asst. Surgeon, from Dept. Arizona to Columbus Bks., Ohio.

First Lieut. R. W. Johnson, Asst. Surgeon, from Dept. Dakota to Dept. East.

First Lieut. Geo. F. Wilson, Asst. Surgeon, from Dept. Columbia to Dept. Dakota. (S. O. 79, A. G. O., April 5, 1886.)

OFFICIAL LIST OF CHANGES IN THE MEDICAL CORPS OF THE U. S. NAVY, DURING THE TWO WEEKS ENDING APRIL 10, 1886.

Atlee, L. W., Asst. Surgeon, ordered to duty on U. S. R. S. "Vermont."

Drake, N. H., P. A. Surgeon, detached from duty at Naval Hospital, Philadelphia, and ordered to duty at Naval Hospital, Brooklyn, N. Y.

Fitts, H. B., P. A. Surgeon, detached from duty at Naval Hospital, Brooklyn, N. Y., and ordered to duty at Naval Hospital, Philadelphia.

Anderson, Frank, P. A. Surgeon, detached from Naval Laboratory, New York, and granted six months' leave from May 1, 1886, with the privilege of going abroad.